SERFF Tracking Number:	*LFCR-125795796*	*State:*	*Arkansas*
Filing Company:	*Berkshire Life Insurance Company of America*	*State Tracking Number:*	*40106*
Company Tracking Number:	*BG01 2008 ENHANCEMENTS AR*		
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*Care ProVider*		
Project Name/Number:	*/*		

Filing at a Glance

Company: Berkshire Life Insurance Company of America

Product Name: Care ProVider	SERFF Tr Num: LFCR-125795796	State: ArkansasLH
TOI: LTC03I Individual Long Term Care	SERFF Status: Closed	State Tr Num: 40106
Sub-TOI: LTC03I.001 Qualified	Co Tr Num: BG01 2008 ENHANCEMENTS AR	State Status: Approved-Closed
Filing Type: Form/Rate	Co Status:	Reviewer(s): Harris Shearer
	Authors: Smith Darlene, Trudy Weigel	Disposition Date: 11/12/2008
	Date Submitted: 08/28/2008	Disposition Status: Approved
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile: Not Filed
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments: Not filed.
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 11/12/2008	
State Status Changed: 11/12/2008	Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

RE: BERKSHIRE LIFE INSURANCE COMPANY OF AMERICA - NAIC # 71714

Long Term Care filing of Tax-Qualified Policy Forms as listed in the attached Form Filing Cover Sheet

As indicated on the Cover Sheet NEW PRODUCT ENHANCEMENTS in the form of five new riders are being filed for your review and approval as new forms.

In addition forms previously approved for use on 4/28/04 and indicated as Previously Approved Forms With Revised Rates For New Policyholders are being submitted with an updated form number to accommodate the new rates for use going forward. Other than the updated form number and the Arkansas Long Term Care Partnership Program Regulation 94 we certify that no other changes have been made to the previously approved forms. All benefits are described in the enclosed actuarial memorandum.

NEW PRODUCT ENHANCEMENTS:
Rider Form BG01R-IP(01/09), Compound Inflation Protection Rider will be offered providing an annual 3%, 4%, 5%, or 6% (insured's choice) increase of previous year's Daily Benefit amount, compounded for life with corresponding increase of pool amount. Benefits will continue to increase regardless of claim status.

A Step Rated Premium Payment option is available with selection of the 5% Compound Inflation Protection Rider. We have included an updated Benefit Schedule that reflects the new Step Rated Premium Schedule. If the applicant elects to pay premiums under the Step Rated Premium Payment Option, Disclosure Form BG01D-SRP(01/09) will be signed by the applicant at time of application.

Rider Form BG01R-FROP(01/09), Full Return of Premium Rider will be offered, providing a return of premium benefit in the event of the death of the insured (last to die under joint coverage). If the insured dies while the policy is in force, the total of premiums paid for the policy and any attached riders will be paid to a beneficiary. Not available with Optional Policy Surrender Rider.

Rider Form BG01R-OPS(01/09), Optional Policy Surrender Rider, provides a policy surrender option after the policy has been in force for at least five years, subject to prior claim payment or current claim considerations. The surrender value will be in the form of a lump sum payment equal to 80% of the total of premium paid for the policy and any attached riders, payable upon satisfactory evidence of insurability.

If satisfactory evidence of insurability is not provided, the surrender value will be offered as a lifetime monthly income benefit, payable until the earlier of death (last to die under joint coverage) or 80% of the total of premium paid for the policy and any attached riders has been paid.

Rider Form BG01R-FDC(01/09), First Day HCCS Benefit Rider, waives any elimination period required for Home and Community Care Services when the insured otherwise satisfies conditions for payment of benefits. No elimination period

will be required and benefits will be payable on the first day the insured is qualified to receive benefits. HCCS benefits used will not count towards satisfaction of the elimination period for Facility Care (FC). This rider is not available with FC Only coverage.

Rider Form BG01R-SBA(01/09), Shared Benefit Amount Rider, is available for benefit periods of less than Lifetime. It provides a second benefit pool on joint policies after either or both insureds have exhausted their FC or HCCS benefit pool under the policy. This rider is not available with the Restoration of Benefits Rider, or FC Only coverage.

The long term care insurance policy and all riders will be applied for on Application BG01A(01/09)-AR or on Simplified Worksite Application BG01SA(01/09)-AR and the Outline of Coverage BG01OC(01/09)-AR will be provided to each applicant at time of application.

As indicated on the Cover Sheet additional previously approved forms (approval date shown above) appear as Previously Approved Forms For Use With this Product.

Finally we are including an actuarial memorandum and flesch certification, both of which address the New Product Enhancements and revised rates for previously approved forms.

Concurrent with this filing, these forms are being filed in the company’s domiciliary state, Massachusetts.

Thank you for your assistance with this filing.

Sincerely,

Amy Ota
Compliance Analyst
(800) 366-5463 ext. 2324

SERFF Tracking Number:	*LFCR-125795796*	*State:*	*Arkansas*
Filing Company:	*Berkshire Life Insurance Company of America*	*State Tracking Number:*	*40106*
Company Tracking Number:	*BG01 2008 ENHANCEMENTS AR*		
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*Care ProVider*		
Project Name/Number:	*/*		

Company and Contact

Filing Contact Information

(This filing was made by a third party - LCA01)

Amy Ota, Compliance Analyst 2
P.O. Box 4243
Woodland Hills, CA 91365-4243

amy.ota@lifecareassuance.com
(818) 867-2324 [Phone]
(818) 867-2508[FAX]

Filing Company Information

Berkshire Life Insurance Company of America
Long Term Care Administrative Office
P.O. Box 4243
Woodland Hills, CA 91365-4243
(818) 867-2450 ext. [Phone]

CoCode: 71714
Group Code: 429
Group Name:
FEIN Number: 75-1277524

State of Domicile: Massachusetts
Company Type:
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$225.00
Retaliatory?	Yes
Fee Explanation:	$150.00 per rate 75.00 per form $225.00 Total
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Berkshire Life Insurance Company of America	$225.00	08/28/2008	22184927

SERFF Tracking Number:	*LFCR-125795796*	*State:*	*Arkansas*
Filing Company:	*Berkshire Life Insurance Company of America*	*State Tracking Number:*	*40106*
Company Tracking Number:	*BG01 2008 ENHANCEMENTS AR*		
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*Care ProVider*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Harris Shearer	11/12/2008	11/12/2008

Amendments

Item	Schedule	Created By	Created On	Date Submitted
Actuarial Memorandum	Rate	Smith Darlene	11/06/2008	11/06/2008
AR Issuer Certification Form	Supporting Document	Smith Darlene	11/06/2008	11/06/2008
First Day HCCS Benefit Rider	Form	Trudy Weigel	10/02/2008	10/02/2008
Partnership Program Notice	Form	Trudy Weigel	10/02/2008	10/02/2008
Actuarial Memorandum	Rate	Trudy Weigel	10/02/2008	10/02/2008

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Issuer Certification Form	Note To Reviewer	Smith Darlene	11/06/2008	11/06/2008
ISSUER CERTIFICATION FORM	Note To Filer	Harris Shearer	11/05/2008	11/05/2008

SERFF Tracking Number:	*LFCR-125795796*	*State:*	*Arkansas*
Filing Company:	*Berkshire Life Insurance Company of America*	*State Tracking Number:*	*40106*
Company Tracking Number:	*BG01 2008 ENHANCEMENTS AR*		
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*Care ProVider*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 11/12/2008
Implementation Date:
Status: Approved
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*LFCR-125795796*	*State:*	*Arkansas*
Filing Company:	*Berkshire Life Insurance Company of America*	*State Tracking Number:*	*40106*
Company Tracking Number:	*BG01 2008 ENHANCEMENTS AR*		
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*Care ProVider*		
Project Name/Number:	*/*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		Yes
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification		Yes
Supporting Document	Outline of Coverage		Yes
Supporting Document	Cover Sheet		Yes
Supporting Document	Flesch Score Certification		Yes
Supporting Document	Benefit Schedule		Yes
Supporting Document	Previously Approved Forms With New Numbers		Yes
Supporting Document	Previously Approved Forms For Use With This Product		Yes
Supporting Document	AR Issuer Certification Form		Yes
Form	Compound Inflation Protection Rider (3%, 4%, 5% and 6% options)		Yes
Form	Full Return of Premium Rider		Yes
Form	Optional Policy Surrender Rider		Yes
Form *(revised)*	First Day HCCS Benefit Rider		Yes
Form	First Day HCCS Benefit Rider	Replaced	Yes
Form	Shared Benefit Amount Rider		Yes
Form	Outline of Coverage for Long Term Care Insurance Policy		Yes
Form	Application for Long Term Care Insurance		Yes
Form	Simplified Worksite Application		Yes
Form	Step Rated Premium Payment Disclosure		Yes
Form	Partnership Disclosure Notice		Yes
Form *(revised)*	Partnership Program Notice		Yes
Form	Partnership Program Notice	Replaced	Yes
Rate *(revised)*	Actuarial Memorandum	Filed	No
Rate	Actuarial Memorandum	Replaced	No
Rate	Actuarial Memorandum	Replaced	No

SERFF Tracking Number:	*LFCR-125795796*	*State:*	*Arkansas*
Filing Company:	*Berkshire Life Insurance Company of America*	*State Tracking Number:*	*40106*
Company Tracking Number:	*BG01 2008 ENHANCEMENTS AR*		
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*Care ProVider*		
Project Name/Number:	*/*		

Amendment Letter

Amendment Date:

Submitted Date: 11/06/2008

Comments:

See attached AR Issuer Certification Form. In addition, we are replacing the Actuarial Memorandum. Thank you for your assistance with this filing.

Changed Items:

Rate/Rule Schedule Item Changes:

Document Name:	Affected Form Numbers: (Comma Separated list)	Rate Action:	Rate Action Information:	Attach Document:
Actuarial Memorandum 2008 ACT MEMO RS.pdf	BG01-1R-IP(01/09) egal	New		2008 ACT MEMO RS.pdf

Supporting Document Schedule Item Changes:

User Added -Name: AR Issuer Certification Form

Comment:

AR Issuer Certification Form.pdf

SERFF Tracking Number:	*LFCR-125795796*	*State:*	*Arkansas*
Filing Company:	*Berkshire Life Insurance Company of America*	*State Tracking Number:*	*40106*
Company Tracking Number:	*BG01 2008 ENHANCEMENTS AR*		
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*Care ProVider*		
Project Name/Number:	*/*		

Note To Reviewer

Created By:
Smith Darlene on 11/06/2008 04:15 PM
Subject:
Issuer Certification Form
Comments:
11/6/08

Per your Note to Filer, I am attaching the Issuer Certification Form.

A revised actuarial memorandum is attached. The rate factors for the Compound Inflation Protection Rider for Limited Pay policies (Attachment D) have been changed. Consequently, the Aggregate Premium Sufficiency table (Attachment E), has been revised. In addition, section XI.G, Statutory Reserves, has been expanded to be more descriptive; Item D of the Actuarial Certification has been changed to refer to the description in section XI.G. Finally, a Premium Comparison exhibit (Attachment F) has been added to demonstrate that the new premium is not lower than the existing plan.

SERFF Tracking Number:	*LFCR-125795796*	*State:*	*Arkansas*
Filing Company:	*Berkshire Life Insurance Company of America*	*State Tracking Number:*	*40106*
Company Tracking Number:	*BG01 2008 ENHANCEMENTS AR*		
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*Care ProVider*		
Project Name/Number:	*/*		

Note To Filer

Created By:

Harris Shearer on 11/05/2008 04:00 PM

Subject:

ISSUER CERTIFICATION FORM

Comments:

PLEASE ATTACH THE RQUIRED FORM.

SERFF Tracking Number:	*LFCR-125795796*	*State:*	*Arkansas*
Filing Company:	*Berkshire Life Insurance Company of America*	*State Tracking Number:*	*40106*
Company Tracking Number:	*BG01 2008 ENHANCEMENTS AR*		
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*Care ProVider*		
Project Name/Number:	*/*		

Amendment Letter

Amendment Date:

Submitted Date: 10/02/2008

Comments:

We have revised the First Day Home and Community Services Benefit Rider, form BG01R-FDC(01/09). Instead of saying "Home and Community Care Services benefits payable as a result of this rider's waiver of the Elimination Period will not count towards the satisfaction of the required Elimination Period for Facility Care Services or any other benefits under the Policy or attached riders" it now reads "Days on which Home and Community Care Services benefits are payable as a result of this rider's waiver of the Elimination Period will also count towards the satisfaction of the required Elimination Period for Facility Care Services or any other benefits under the Policy or attached riders." The actuarial memorandum has also been revised to reflect this change and to increase the rate factors.

Upon further review of form BG01N-PRT(01/09)-AR, Important Consumer Information Regarding the Arkansas Long-Term Care Insurance Partnership Program, it was noticed that the company name was incorrect in the text. The name of the company has been corrected to Berkshire Life Insurance Company of America. Attached is a corrected Partnership Program Notice that reflects this change.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
BG01R-FDC(01/09)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	First Day HCCS Benefit Rider	Initial				58	BG01R-FDC(01-09).pdf

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
BG01N-PRT(01/09)-	Other	Partnership Program	Initial					BG01N-PRT(01-09)-

SERFF Tracking Number:	*LFCR-125795796*	*State:*	*Arkansas*
Filing Company:	*Berkshire Life Insurance Company of America*	*State Tracking Number:*	*40106*
Company Tracking Number:	*BG01 2008 ENHANCEMENTS AR*		
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*Care ProVider*		
Project Name/Number:	*/*		

AR Notice AR.pdf

SERFF Tracking Number:	*LFCR-125795796*	*State:*	*Arkansas*
Filing Company:	*Berkshire Life Insurance Company of America*	*State Tracking Number:*	*40106*
Company Tracking Number:	*BG01 2008 ENHANCEMENTS AR*		
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*Care ProVider*		
Project Name/Number:	*/*		

Rate/Rule Schedule Item Changes:

Document Name:	Affected Form Numbers: (Comma Separated list)	Rate Action:	Rate Action Information:	Attach Document:
Actuarial Memorandum 2008 ACT MEMO RS - AR.pdf	BG01-1R-IP(01/09) eg al	New		2008 ACT MEMO RS - AR.pdf

SERFF Tracking Number:	*LFCR-125795796*	*State:*	*Arkansas*
Filing Company:	*Berkshire Life Insurance Company of America*	*State Tracking Number:*	*40106*
Company Tracking Number:	*BG01 2008 ENHANCEMENTS AR*		
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*Care ProVider*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number: BG01-1R-IP(01/09)

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	BG01R-IP(01/09)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Compound Inflation Protection Rider (3%, 4%, 5% and 6% options)	Initial		55	BG01R-IP(01-09).pdf
	BG01R-FROP(01/09)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Full Return of Premium Rider	Initial		59	BG01R-FROP(01-09).pdf
	BG01R-OPS(01/09)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Optional Policy Surrender Rider	Initial		53	BG01R-OPS(01-09).pdf
	BG01R-FDC(01/09)	Policy/Contract/Fraternal Certificate: Amendmen	First Day HCCS Benefit Rider	Initial		58	BG01R-FDC(01-09).pdf

SERFF Tracking Number:	*LFCR-125795796*	*State:*	*Arkansas*	
Filing Company:	*Berkshire Life Insurance Company of America*	*State Tracking Number:*	*40106*	
Company Tracking Number:	*BG01 2008 ENHANCEMENTS AR*			
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*	
Product Name:	*Care ProVider*			
Project Name/Number:	*/*			

	t, Insert Page, Endorsement or Rider				
BG01R-SBA(01/09)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Shared Benefit Amount Rider	Initial	53	BG01R-SBA(01-09).pdf
BG01OC(01/09)-AR	Outline of Coverage	Outline of Coverage for Long Term Care Insurance Policy	Initial	0	BG01OC(01-09)-AR.pdf
BG01A(01/09)-AR	Application/Enrollment Form	Application for Long Term Care Insurance	Initial	0	BG01A(01-09)-AR.pdf
BG01SA(01/09)-AR	Application/Enrollment Form	Simplified Worksite Application	Initial	0	BG01SA(01-09)-AR.pdf
BG01D-SRP(01/09)	Other	Step Rated Premium Payment Disclosure	Initial	0	BG01D-SRP(01-09).pdf
BG01D-PRT(01/09)-AR	Other	Partnership Disclosure Notice	Initial		BG01D-PRT(01-09)-AR.pdf
BG01N-PRT(01/09)-AR	Other	Partnership Program Notice	Initial		BG01N-PRT(01-09)-AR.pdf

Berkshire Life Insurance Company of America
Home Office: Pittsfield, Massachusetts
Long Term Care Administrative Office
Post Office Box 4243
Woodland Hills, CA 91365-4243
888-505-8743

COMPOUND INFLATION PROTECTION RIDER

READ THIS RIDER CAREFULLY. It is a part of a legal contract between you and us.

This rider is part of the Policy. The Effective Date for this rider is shown on the Policy Schedule of the attached Policy. It is issued in consideration of your application and premium paid by you for this rider. All definitions, provisions, Limitations and Exclusions of the Policy apply to this rider unless changed by this rider.

Compound Inflation Protection

On each Policy Anniversary Date, we will increase the Daily Benefit shown on the Policy Schedule. The increase will be based on the previous year's Daily Benefit amount, at the percentage increase rate selected on your application and shown on the Policy Schedule.

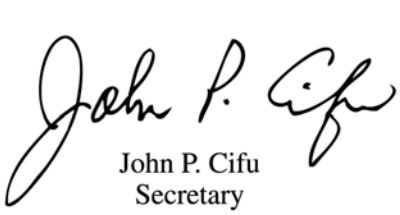
On each Policy Anniversary Date, we will also increase by the same percentage increase rate the remaining: Benefit Amount; the Maximum Lifetime Alternative Plan of Care benefit and if shown on the Policy Schedule; the Maximum Lifetime Caregiver Training benefit and either the Maximum Benefit Amount with Restoration of Benefits or the Shared Benefit Amount.

Benefits will continue to increase annually while the Policy is in force, including while you are receiving benefits under the Policy.

Free Look Period For 30 Days

If you are not satisfied with this rider, you may return it to us or any authorized agent or agency within 30 days from the date you receive it. We will then refund any premium you have paid for this rider and this rider will be considered never to have been in effect.

Executed for the Company at its Home Office in Pittsfield, Massachusetts.



John P. Cifu
Secretary

Joan Bancroft
President

Berkshire Life Insurance Company of America
Home Office: Pittsfield, Massachusetts
Long Term Care Administrative Office
Post Office Box 4243
Woodland Hills, CA 91365-4243
888-505-8743

FULL RETURN OF PREMIUM RIDER

READ THIS RIDER CAREFULLY. It is a part of a legal contract between you and us.

This rider is part of the Policy. The Effective Date for this rider is shown on the Policy Schedule of the attached Policy. It is issued in consideration of your application and premium paid by you for this rider. All definitions, provisions, Limitations and Exclusions of the Policy apply to this rider unless changed by this rider.

Full Return of Premium

If you die (last of your deaths under joint coverage) while the Policy is in force, the total of premiums paid will be paid to your Beneficiary. There will be no additional refund of premiums as described under the Refund of Unearned Premium provision in the Policy.

Beneficiary

The Beneficiary will be the person or persons, named in the application or subsequently changed by written request, to receive any unassigned benefit payments due upon your death (last of your deaths under joint coverage).

You may change the Beneficiary at any time by giving us written notice. A change will not be effective until recorded by us. Once recorded, the change will apply as of the date the request was signed. We will not be liable for any action taken or payment made before a Beneficiary change is recorded. The Beneficiary's consent is not required to change the Policy or Beneficiary, unless the designation of the Beneficiary is irrevocable.

If you designate more than one person as Beneficiary, the interests of all Beneficiaries will be equal unless your designation specifically provides otherwise. The share of any Beneficiary who does not survive you shall pass equally to the surviving Beneficiaries, unless your designation specifically provides otherwise. If no Beneficiary is designated or no Beneficiary survives you, then your estate will be the Beneficiary.

Free Look Period For 30 Days

If you are not satisfied with this rider, you may return it to us or any authorized agent or agency within 30 days from the date you receive it. We will then refund any premium you have paid for this rider and this rider will be considered never to have been in effect.

Executed for the Company at its Home Office in Pittsfield, Massachusetts.

John P. Cifu
Secretary

Joan Bancroft
President

Berkshire Life Insurance Company of America
Home Office: Pittsfield, Massachusetts
Long Term Care Administrative Office
Post Office Box 4243
Woodland Hills, CA 91365-4243
888-505-8743

OPTIONAL POLICY SURRENDER RIDER

READ THIS RIDER CAREFULLY. It is a part of a legal contract between you and us.

This rider is part of the Policy. The Effective Date for this rider is shown on the Policy Schedule of the attached Policy. It is issued in consideration of your application and premium paid by you for this rider. All definitions, provisions, Limitations and Exclusions of the Policy apply to this rider unless changed by this rider.

Optional Policy Surrender

If the Policy has been in force for five or more years and you meet the following conditions, you may surrender the Policy by written request (from both insureds under joint coverage) to us:

(a) you have not received benefit payments under the Policy that total more than 365 days;

(b) you are not currently receiving benefits under the Policy; and

(c) you have not filed a claim that is currently under consideration.

The surrender value will be a lump sum payment equal to 80% of the total of premiums paid for the Policy and any attached riders as of the date of surrender. This will be payable upon evidence of insurability satisfactory to us under our underwriting guidelines in effect at the time of surrender. We will send you an application form that you will need to complete and return to us, along with a newly signed and currently dated Authorization for Disclosure, Receipt and Use of Personal Health Information. If we determine you are eligible for a lump sum payment, this payment will be provided to you and we will terminate the Policy as of the date of your written request for surrender.

If you are not approved by underwriting for the lump sum payment (both insureds must be approved under joint coverage), **or** if you choose not to submit evidence of insurability, we will offer to pay you a lifetime monthly income benefit. This benefit will be payable until the earlier of: (a) your death (last of your deaths under joint coverage); or (b) 80% of the total of premiums paid for the Policy and any attached riders has been paid to you. Upon your acceptance of our offer (both insureds' acceptance under joint coverage), we will terminate the Policy as of the date of your request for surrender. If you do not choose to accept this offer, you may keep your existing coverage in force by the timely payment of any premiums due.

(over)

The table below illustrates the method for calculating the monthly income benefit. Calculations for any additional ages not shown can be provided upon request.

Under joint coverage the older insureds age will be used for calculating the monthly income benefit.

If the monthly income benefit is being paid, upon the death of one joint insured, the remaining insured will receive the same monthly income benefit.

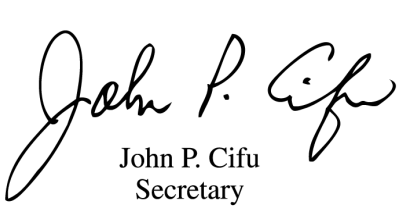
Schedule of Monthly Payments per $1,000 of Surrender Value

Age Nearest Birthdate At Surrender	Single Life	Joint Life	Age Nearest Birthdate At Surrender	Single Life	Joint Life
40	3.14	2.84	71	6.18	4.80
41	3.18	2.87	72	6.41	4.94
42	3.22	2.90	73	6.66	5.09
43	3.27	2.93	74	6.93	5.25
44	3.31	2.96	75	7.22	5.43
45	3.36	2.99	76	7.54	5.62
46	3.41	3.02	77	7.88	5.82
47	3.46	3.06	78	8.25	6.04
48	3.51	3.10	79	8.64	6.27
49	3.57	3.14	80	9.07	6.52
50	3.63	3.18	81	9.53	6.80
51	3.69	3.22	82	10.03	7.09
52	3.76	3.26	83	10.57	7.40
53	3.83	3.31	84	11.16	7.74
54	3.90	3.36	85	11.78	8.10
55	3.98	3.41	86	12.46	8.50
56	4.06	3.46	87	13.18	8.92
57	4.15	3.52	88	13.94	9.37
58	4.24	3.58	89	14.76	9.85
59	4.34	3.65	90	15.62	10.37
60	4.45	3.71	91	16.52	10.91
61	4.56	3.78	92	17.47	11.50
62	4.67	3.86	93	18.46	12.11
63	4.80	3.94	94	19.50	12.77
64	4.93	4.03	95	20.60	13.46
65	5.08	4.12	96	21.77	14.20
66	5.23	4.21	97	23.03	14.99
67	5.39	4.32	98	24.43	15.85
68	5.57	4.42	99	26.01	16.79
69	5.76	4.54	100	27.81	17.83
70	5.96	4.66			

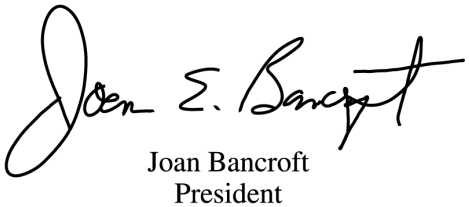
Free Look Period For 30 Days

If you are not satisfied with this rider, you may return it to us or any authorized agent or agency within 30 days from the date you receive it. We will then refund any premium you have paid for this rider and this rider will be considered never to have been in effect.

Executed for the Company at its Home Office in Pittsfield, Massachusetts.



John P. Cifu
Secretary



Joan Bancroft
President

Berkshire Life Insurance Company of America
Home Office: Pittsfield, Massachusetts
Long Term Care Administrative Office
Post Office Box 4243
Woodland Hills, CA 91365-4243
888-505-8743

FIRST DAY HOME AND COMMUNITY CARE SERVICES BENEFIT RIDER

READ THIS RIDER CAREFULLY. It is a part of a legal contract between you and us.

This rider is part of the Policy. The Effective Date for this rider is shown on the Policy Schedule of the attached Policy. It is issued in consideration of your application and premium paid by you for this rider. All definitions, provisions, Limitations and Exclusions of the Policy apply to this rider unless changed by this rider.

First Day Home and Community Care Services Benefit

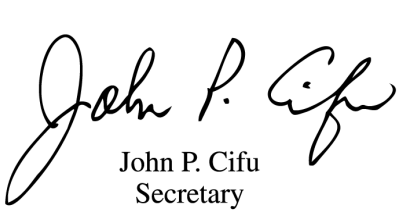
We will waive any Elimination Period required for Home and Community Care Services benefits. If you otherwise satisfy the Payment of Benefits provision under the Policy for Home and Community Care Services, no Elimination Period will be required and benefits will be payable on the first day you are qualified to receive benefits.

Days on which Home and Community Care Services benefits are payable as a result of this rider's waiver of the Elimination Period will also count towards the satisfaction of the required Elimination Period for Facility Care Services or any other benefits under the Policy or attached riders.

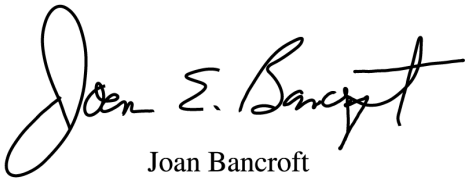
Free Look Period For 30 Days

If you are not satisfied with this rider, you may return it to us or any authorized agent or agency within 30 days from the date you receive it. We will then refund any premium you have paid for this rider and this rider will be considered never to have been in effect.

Executed for the Company at its Home Office in Pittsfield, Massachusetts.



John P. Cifu
Secretary



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SHARED BENEFIT AMOUNT RIDER

READ THIS RIDER CAREFULLY. It is a part of a legal contract between you and us.

This rider is part of the Policy. The Effective Date for this rider is shown on the Policy Schedule of the attached Policy. It is issued in consideration of your application and premium paid by you for this rider. All definitions, provisions, Limitations and Exclusions of the Policy apply to this rider unless changed by this rider.

Shared Benefit Amount

In the event either or both of you exhaust your Benefit Amount under the Policy and you otherwise satisfy the Payment of Benefits provision, a joint Shared Benefit Amount will become accessible to you. The Shared Benefit Amount will be equal to the Benefit Amount shown on the Policy Schedule and will be payable for covered Qualified Long Term Care Services you receive. This Shared Benefit Amount may be accessed by either or both insureds while there is a remaining Shared Benefit Amount available.

Payment will be the actual daily Facility Care Services or Home and Community Care Services charges you incur, up to the Daily Benefit shown on the Policy Schedule. We will subtract benefits we pay from the Shared Benefit Amount.

Subject to the additional terms as described in the Policy Termination provision of the Policy, your coverage will end on the date the total of all benefits payable under the Shared Benefit Amount shown on the Policy Schedule have been paid to you. If only one of you has exhausted the Shared Benefit Amount and the other insured has a remaining Benefit Amount payable under the Policy, coverage will continue for that insured as described in the Joint Coverage provision of the Policy.

If one of you dies or terminates coverage as described in the Policy Termination provision of the Policy, any benefits remaining under the Shared Benefit Amount will be payable to the remaining insured, subject to the conditions outlined above. If each of you elects to convert joint coverage to separate individual policies, the Shared Benefit Amount Rider will terminate upon such conversion.

Free Look Period For 30 Days

If you are not satisfied with this rider, you may return it to us or any authorized agent or agency within 30 days from the date you receive it. We will then refund any premium you have paid for this rider and this rider will be considered never to have been in effect.

Executed for the Company at its Home Office in Pittsfield, Massachusetts.

John P. Cifu
Secretary

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OUTLINE OF COVERAGE FOR LONG TERM CARE INSURANCE POLICY FORM BG01P(01/09)-AR

NOTICE TO BUYER: This policy may not cover all of the costs associated with long term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations.

Caution: The issuance of this Long Term Care Insurance Policy is based upon your responses to the questions in your application. A copy of your application is enclosed. If responses are incorrect or untrue, the Company may have the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact us at the address shown above.

The policy is an individual policy of insurance.

PURPOSE OF OUTLINE OF COVERAGE

This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not the insurance contract, but only a summary of coverage. Only the individual policy contains governing contractual provisions. This means that the policy sets forth in detail the rights and obligations of both you and the Company. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR POLICY CAREFULLY!

FEDERAL TAX CONSEQUENCES

THE POLICY IS INTENDED TO BE A FEDERALLY TAX-QUALIFIED LONG TERM CARE INSURANCE CONTRACT AS DEFINED UNDER SECTION 7702B(b) OF THE INTERNAL REVENUE CODE OF 1986, as amended, and will be endorsed to conform to changes in that definition. You should consult with your attorney, accountant, or tax advisor regarding the tax implications of purchasing this long term care insurance.

TERMS UNDER WHICH THE POLICY MAY BE CONTINUED IN FORCE OR DISCONTINUED

RENEWABILITY: THE POLICY IS GUARANTEED RENEWABLE. This means you have the right, subject to the terms of the policy, to continue the policy as long as you pay your premiums on time. Berkshire Life Insurance Company of America cannot change any of the terms of the policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.

Waiver of Premium

Premiums for the policy and attached riders will be waived after you (either insured under joint coverage) have been confined in a nursing facility or assisted living facility for a period of 90 days and you satisfy the conditions on Eligibility for Payment of Benefits. The 90 days need not be consecutive, but must be satisfied during a Single Claim Period. We will return any unearned premium to you on a pro-rata basis. Premium paid during the 90-day period described above will be considered unearned and also returned to you. The premium will be waived until you no longer satisfy the conditions on Eligibility for Payment of Benefits (because you have recovered and you are no longer confined in a nursing facility or assisted living facility). Premium payments will then again become due. Any new Single Claim Period will require satisfaction of a new 90-day waiting period for Waiver of Premium, as described above. For an additional premium payment, an optional Waiver of Premium Rider is also available, as described below.

TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS

Premiums are subject to change. We can only change the premium for the policy if we change premiums for everyone in your state with the same policy form. We will give you at least 60 days written notice at your last address shown in our records before we change your premium.

TERMS UNDER WHICH THE POLICY MAY BE RETURNED AND PREMIUM REFUNDED

If you are not satisfied with your policy, you have 30 days to return it to us or any authorized agent or agency for a full refund of any premium you have paid. Upon your death (last of your deaths under joint coverage), we will refund any unearned premium for the policy on a pro-rata basis. We will make this refund within 30 days of our receipt of proof of your death. If you cancel the policy after 30 days, any unearned premium will be refunded to you on a pro-rata basis. If you purchase the optional Full Return of Premium Rider, all or a portion of the premiums paid for the policy and riders will be returned to your beneficiary upon your death (last of your deaths under joint coverage).

THIS IS NOT MEDICARE SUPPLEMENT COVERAGE

If you are eligible for Medicare, review the *Guide to Health Insurance for People with Medicare* available from us. Neither Berkshire Life Insurance Company of America nor its agents represent Medicare, the federal government or any state government.

LONG TERM CARE COVERAGE

Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, Maintenance or Personal Care Services provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community or in the home.

The policy provides coverage for Qualified Long Term Care Services in the form of an expense-incurred benefit for covered long term care expenses, subject to policy Elimination Periods, Limitations and Exclusions described below.

BENEFITS PROVIDED BY THE POLICY

Covered Services

The policy provides benefits for Qualified Long Term Care Services performed in a nursing facility or an assisted living facility and Maintenance or Personal Care Services performed in an assisted living facility. Benefits are also provided for Facility Bed Reservation, Respite Care Services and an Alternative Plan of Care. In addition, you may select coverage under the policy for Home and Community Care Services, including benefits for home health care, adult day care, hospice services and Caregiver Training. An Emergency Response System benefit is also available when Home and Community Care Services are selected.

Elimination Period

This is the number of days you must satisfy the conditions on Eligibility for Payment of Benefits and receive either Facility Care Services or Home and Community Care Services (if covered under the policy) before we will begin paying benefits. You may choose an Elimination Period of 0, 30, 90 or 180 days. Once you have satisfied the Elimination Period, no future Elimination Period is required. Days may be accumulated under separate claims in order to satisfy the Elimination Period. The Elimination Period applies to each insured individually under joint coverage.

Benefit Amount

You may choose an unlimited Benefit Amount for Lifetime coverage, or a lesser amount determined by multiplying the Daily Benefit selected by the Benefit Period selected (2,190 days (6 years), 1,825 days (5 years), 1,460 days (4 Years) or 1,095 days (3 Years)). The result will be your Benefit Amount for all benefits payable under the policy. Under joint coverage, the policy provides for a separate Benefit Amount for each insured. For an additional premium payment, a Shared Benefit Amount Rider is also available, as described below.

Coverage Outside the United States

Benefits are payable for Qualified Long Term Care Services received outside the United States or its territories, or Canada for up to 30 days per calendar year. The benefit payable under the policy will be the actual daily charges you incur for covered services, up to the Daily Benefit you select. Benefits paid are subtracted from the Benefit Amount.

Facility Care Services Benefit

Benefits are payable for Qualified Long Term Care Services (including skilled, intermediate or custodial nursing care) provided to you in a nursing facility or assisted living facility and Maintenance or Personal Care Services performed in an assisted living facility. The benefit payable under the policy will be the actual daily Facility Care Services charges you

incur, up to the Daily Benefit you select. You may choose a Daily Benefit of up to $400 per day. Premium rates will vary according to the Daily Benefit you select. Benefits paid are subtracted from the Benefit Amount.

Facility Bed Reservation Benefit

This benefit is payable if you are receiving Facility Care Services benefits under the policy, you incur a temporary absence from the facility and are charged by the nursing facility or assisted living facility to reserve your accommodations. The benefit payable will be the actual daily charges you incur for the reservation, up to the Daily Benefit selected. This benefit is payable for a maximum of 30 days per calendar year. Benefits paid are subtracted from the Benefit Amount.

Home and Community Care Services Benefit

This benefit will only be covered under the policy if it is selected by you and shown on the Policy Schedule page of the policy. Benefits are payable for home health care provided through a qualified Home Health Care Agency or Independent Home Health Caregiver, in a setting other than a hospital, nursing facility or assisted living facility. Home health care includes professional nursing care by or under the supervision of an RN or other licensed nurse; care by a qualified Home Health Aide; therapeutic care services by or under the supervision of a speech, occupational, physical, or respiratory therapist, licensed or certified under state law, if any; services provided by a registered dietician or homemaker services. Benefits are also payable for adult day care, hospice services and Caregiver Training.

The benefit payable under the policy will be the actual Home and Community Care Services charges you incur, up to the Daily Benefit you select. Premium rates will vary according to the Daily Benefit you select. Benefits paid are subtracted from the Benefit Amount.

Emergency Response System

This benefit is payable if you are receiving Home and Community Care Services benefits under the policy. We will reimburse you for charges you incur for use of this system, up to $50 per month. This will include a device or system installed in your residence that provides you with a means of communication to request assistance in the event of a medical emergency. Benefits paid are subtracted from the Benefit Amount.

Caregiver Training Benefit

If Home and Community Care Services are selected, this benefit provides for training by a health care professional to an informal caregiver. The informal caregiver may be an unpaid member of your Family, a friend or neighbor.

The benefit payable under the policy will be the actual Caregiver Training charges incurred, up to a Maximum Lifetime Caregiver Training Benefit that is equal to 5 times the Daily Benefit selected. You need not satisfy the Elimination Period to receive this benefit; however, use of the benefit does not count toward satisfaction of the Elimination Period for any other benefits payable under the policy. Benefits paid are subtracted from the Benefit Amount.

Respite Care Services Benefit

Benefits are payable for Qualified Long Term Care Services provided on a short term basis to relieve Family or friends who are the primary caregivers in your residence. Such services may be provided in your home, a nursing facility, assisted living facility or through a community based program.

The benefit payable under the policy will be the actual daily Facility Care Services or if selected, Home and Community Care Services charges incurred, up to the Daily Benefit chosen. The Respite Care Services Benefit is payable for a maximum of 30 days per calendar year. You need not satisfy the Elimination Period to receive this benefit; however, use of the benefit does not count toward satisfaction of the Elimination Period for any other benefits payable under the policy. Benefits paid are subtracted from the Benefit Amount.

Alternative Plan of Care Benefit

If you are Chronically Ill an Alternative Plan of Care is available, if agreed to by you, your Licensed Health Care Practitioner and us. The Maximum Lifetime Alternative Plan of Care payable under the policy is equal to 50 times the Daily Benefit selected. The Alternative Plan of Care benefit amount agreed upon, divided by the Daily Benefit selected, equals the number of subsequent days for which we will not pay additional benefits for Home and Community Care Services or Facility Care Services under the policy. This number of subsequent days will be considered to have been paid by the Alternative Plan of Care benefit amount agreed to. An Alternative Plan of Care provides for Qualified Long Term

Care Services not specifically shown as being available under the policy including: equipment purchases or rentals; permanent or temporary modifications to your residence (such as ramps or rails), or care services not normally covered under Home and Community Care Services. The Alternative Plan of Care is not available for providing Home and Community Care Services benefits on policies providing benefits for Facility Care Services only. We reserve the right to make the final decision on any request for the Alternative Plan of Care Benefit. Benefits paid are subtracted from the Benefit Amount.

Optional Personal Care Advisor

An Optional Personal Care Advisor will be available if requested by you to assist you with questions regarding such matters as: Eligibility for Payment of Benefits; appropriate level of care; availability of facilities and other care and service resources in your area; or any other questions you may have about a claim for benefits. You may contact your Personal Care Advisor by calling the toll-free number which will be shown on the Policy Schedule page of the policy. You are not required to use these services in order to file a claim, there is no cost to you for their use and no benefits will be deducted from the Benefit Amount.

Optional Care Coordination

At your request, if you need Care Coordination assistance related to filing a claim, you may call the toll-free number which will be shown on the Policy Schedule page of the policy and we will arrange for a care coordinator to contact you. The care coordinator will be an RN and will: assess and coordinate appropriate care and services; provide assistance in the development of a Plan of Care; if you wish, maintain a continuing role in the arrangement and monitoring of services and assist with necessary claims documentation. You are not required to use these services in order to file a claim, there is no cost to you for their use and no benefits will be deducted from the Benefit Amount.

Definitions

Activities of Daily Living:

- Bathing: Washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.
- Continence: The ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).
- Dressing: Putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.
- Eating: Feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.
- Toileting: Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
- Transferring: Moving into or out of a bed, chair or wheelchair.

Family means you or your spouse and those related to you or your spouse; including a parent, sibling, child, grandparent or grandchild (including any of his or her in-laws, step or legally adopted relatives).

Hands-On Assistance means the physical assistance of another person without which you would be unable to perform the Activity of Daily Living.

Home Health Aide means a person, other than an RN or nurse, who provides Maintenance or Personal Care Services through a Home Health Care Agency. A Home Health Aide must be licensed or certified under state law, if any, and acting within the scope of his or her license or certification at the time the treatment or service is performed.

Home Health Care Agency means a hospital, agency, or other provider licensed or certified under state law, if any, to provide Home Health Care.

Independent Home Health Caregiver means a person who is approved by us; and

- is independently employed and not associated with a Home Health Care Agency;
- provides care within the scope of his or her employment in the performance of Qualified Long Term Care Services; and

- is licensed or certified under state law, if any, and acting within the scope of his or her license at the time the treatment or service is performed.

Licensed Health Care Practitioner means:

- a physician;
- a registered nurse; or
- a licensed social worker.

The Licensed Health Care Practitioner must not be a member of your Family.

Maintenance or Personal Care Services means any care provided primarily to give needed assistance to you as a result of your being Chronically Ill (including protection of your health and safety due to a Severe Cognitive Impairment).

Plan of Care means a written plan prescribed by a Licensed Health Care Practitioner developed in consultation with you, based upon an assessment indicating you are Chronically Ill. The Plan of Care will recommend the necessary services to be performed. In addition, it will specifically identify the frequency and type of services most suitable to meet your needs, as well as the most appropriate providers for such services. The Plan of Care is updated as your needs change.

Qualified Long Term Care Services means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating and rehabilitative services and Maintenance or Personal Care Services, which are required by you when you are Chronically Ill and are provided pursuant to a Plan of Care.

Severe Cognitive Impairment means your deterioration or loss of intellectual capacity, which requires Substantial Supervision by another person to protect yourself or others from threats to health and safety. It is measured by clinical evidence and standardized tests that reliably measure your impairment in:

- short or long term memory;
- your orientation as to person (such as who you are), place (such as your location) and time (such as day, date and year); and
- deductive or abstract reasoning.

A Severe Cognitive Impairment includes Alzheimer's disease and similar forms of irreversible dementia.

Single Claim Period means a claim for benefits under the policy that is not interrupted by a period of 180 consecutive days. If you do not satisfy the conditions on Eligibility for Payment of Benefits (because you have recovered and you are no longer receiving benefits under the policy) for 180 consecutive days or longer, a new Single Claim Period will be established.

Stand-By Assistance means the presence of another person within arm's reach of you that is necessary to prevent, by physical intervention, injury to you while you are performing the Activity of Daily Living.

Substantial Assistance means Hands-On or Stand-By Assistance.

Substantial Supervision means continual supervision by another person to protect you or others from threats to health or safety (such as may result from wandering) when you have a Severe Cognitive Impairment. Such supervision may include cueing by verbal prompting, gestures or other similar demonstrations.

Eligibility for Payment of Benefits

You will satisfy the conditions on Eligibility for Payment of Benefits if you are a Chronically Ill individual, which means that within the previous 12 months you have been certified by a Licensed Health Care Practitioner as: being unable to perform, without Substantial Assistance, at least two Activities of Daily Living for an expected period of at least 90 days due to loss of functional capacity; or having a Severe Cognitive Impairment.

The expected 90-day period for loss of functional capacity does not establish a waiting period beyond any Elimination Period selected before benefits become payable under the policy.

LIMITATIONS OR CONDITIONS ON ELIGIBILITY FOR PAYMENT OF BENEFITS

Non-Eligible Facilities

A nursing facility does not include a hospital, convalescent home, board and rest home, home for the aged, residential care facility, domiciliary and retirement care facility, training center or government or veteran's facility or any other facility where the patient is not required to pay. An assisted living facility does not include a hospital.

Limitations and Exclusions

No benefits will be paid under the policy for confinement in:

- Non-eligible facilities; or
- an unlicensed facility (if licensing is required in your state).

No benefits will be paid and the Elimination Period will not be satisfied for any confinement, care, treatment or service(s):

- provided to you by a person in your Family;
- provided outside of the United States or its territories, or Canada, except as described above under Coverage Outside the United States;
- for which you have no financial liability or that is provided at no charge in the absence of insurance;
- provided in facilities operated primarily for the treatment of alcoholism or drug addiction; or
- provided in facilities operated primarily for the treatment of mental or nervous disorders. However, this shall not operate to exclude coverage for loss which results from Alzheimer's or any other demonstrable organic disease such as senile dementia.

Non-Duplication of Benefits

Benefits are not payable under the policy for expenses incurred to the extent that such expenses are reimbursable under Medicare or would be so reimbursable but for the application of a deductible or coinsurance amount; or for any other state or federal worker's compensation plan, or other governmental program (except Medicaid).

For purposes of satisfying the Elimination Period, days on which you satisfy the conditions on Eligibility for Payment of Benefits, but coverage is excluded due to the Non-Duplication of Benefits provision, will count toward satisfaction of the Elimination Period.

Payment of Benefits

While the policy is in force, you will receive benefits if:

- you satisfy Eligibility for Payment of Benefits;
- you have satisfied any applicable Elimination Period shown on the Policy Schedule page of the policy;
- you receive services covered under the policy pursuant to a Plan of Care;
- you are not receiving any other benefits covered under the policy;
- you have not been paid benefits that exceed the Benefit Amount or if shown on the Policy Schedule page of the policy, the Maximum Benefit Amount With Restoration of Benefits or the Shared Benefit Amount;
- your claim is properly filed according to the requirements described in the policy; and
- your claim is not subject to any Limitations and Exclusions contained in the policy.

THE POLICY MAY NOT COVER ALL EXPENSES ASSOCIATED WITH YOUR LONG TERM CARE NEEDS.

RELATIONSHIP OF COST OF CARE AND BENEFITS

Because the costs of long term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. The benefit levels of the basic policy will not increase over time. For an additional premium payment, you may purchase the optional Compound Inflation Protection Rider described below.

ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS

Subject to Eligibility for Payment of Benefits, Payment of Benefits, any Limitations and Exclusions described above, the policy provides coverage if you are clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses.

PREMIUM

10-Year and Paid-up at 65 Premium Payment Options

These options provide that at the end of the premium payment period if each required premium has been paid, the policy will automatically be renewed for the rest of your life with no further premium payments required. During the premium payment period, premiums will be subject to change as described under "TERMS UNDER WHICH THE POLICY MAY BE CONTINUED IN FORCE OR DISCONTINUED" on the first page of this outline of coverage.

Long Term Care Insurance Policy

* *If a PARTNERSHIP POLICY is selected below and you are age **75 or younger**, the 3%, 4%, 5% **or** 6% Compound Inflation Protection Rider must be selected and will be issued with your policy.*

❍ Partnership Policy ☒ Non-Partnership Policy

Elimination Period: ❍ 0 Days ❍ 30 Days ☒ 90 Days ❍ 180 Days

Daily Benefit ($50 - $400): $ $150.00

Benefit Period: ❍ Lifetime ❍ 2,190 Days (6 Years) ❍ 1,460 Days (4 Years)
☒ 1,825 Days (5 Years) ❍ 1,095 Days (3 Years)

The following are the Annual Premiums for the coverage you have applied for:

Comprehensive coverage is Facility Care Services plus Home and Community Care Services (HCCS)

	Premium
Select only one of the following coverage combinations:	
❍ Facility Care Services Only	$
❍ Facility Care Services Only with Indemnity Benefit Rider (Form BG01R-IND(01/09))	$
☒ Comprehensive	$ $1,050.85
❍ Comprehensive with Indemnity Benefit Rider (Form BG01R-IND(01/09))	$
❍ Comprehensive with Monthly Benefit Rider (Form BG01R-MTH(06/04)) (*Compound Inflation Protection must also be selected)*	$
Inflation Protection Rider (select only one) *:	
❍ Compound 6% (Form BG01R-IP(01/09))	$
☒ Compound 5% (Form BG01R-IP(01/09))	$ $557.37
❍ Compound 4% (Form BG01R-IP(01/09))	$
❍ Compound 3% (Form BG01R-IP(01/09))	$
Nonforfeiture Benefit Rider:	
☒ Shortened Benefit Period Nonforfeiture (Form BG01R-SBN(06/04))	$ $342.58
Return of Premium Rider:	
❍ Full Return of Premium (Form BG01R-FROP(01/09))	$
Benefit Extension Riders (select only one): (Not available with Lifetime Benefit Period)	
❍ Restoration of Benefits (Form BG01R-ROB(01/09))	$
❍ Shared Benefit Amount (Form BG01R-SBA(01/09)) *(Available only with joint coverage)*	$
Additional Riders:	
❍ Waiver of Premium Benefit (Form BG01R-WOP(01/09)) *(Not available with Facility Care Services Only coverage)*	$
❍ First Day HCCS Benefit (Form BG01R-FDC(01/09)) *(Not available with Facility Care Services Only coverage)*	$
❍ Paid-Up Survivor (Form BG01R-SVR(06/04)) *(Available only with joint coverage and Lifetime Premium Payment Option)*	$
❍ Optional Policy Surrender (Form BG01R-OPS(01/09)) *(Not available with Full Return of Premium Rider or Shortened Benefit Period Nonforfeiture Rider)*	$
Premium Payment Options: ❍ Lifetime	
❍ 10-Year Premium	$
❍ Paid-Up At Age 65 Premium **(Available to age 55)**	$
(if Lifetime Premium and Compound Inflation Protection have been selected above, indicate the payment option):	
☒ Standard Premium Payment Option ❍ Step Rated Premium Payment Option	
TOTAL ANNUAL PREMIUM:	$ $1,950.80

ADDITIONAL FEATURES

Medical Underwriting

Your insurability for the policy will be determined by the answers given in your application and any other authorized medical information we obtain regarding your current state of health.

Modes of Premium Payment

Premiums may be paid on an annual, semi-annual or quarterly basis, or by monthly automatic premium plan. We will change the mode of premium payment if we receive a proper written request at our Long Term Care Administrative Office before the premium due date. The amount of each modal premium is calculated by multiplying the annual policy premium by the applicable modal factors. Modal Factors are: Semi-Annually (0.52), Quarterly (0.27) and Monthly (0.088). The modal premiums will be shown on the Policy Schedule page of the policy.

Grace Period

Except for the first premium, you will have 31 days after each due date to pay the premium due. The policy remains in force during the Grace Period.

Unintentional Lapse

If your premium is not paid by the 30th day of the Grace Period, we will provide written notice to you and any individuals designated by you to receive notice of non-payment of premium. Notice will be sent at least 30 days before cancellation of your coverage. If your premium is not paid within 35 days after notice is sent, the policy will lapse for non-payment of premium.

Nonforfeiture Benefits

If you choose not to select the following optional nonforfeiture rider, a contingent benefit upon lapse will be available if: (a) the policy lapses as described under the Grace Period and Unintentional Lapse provisions of the policy; and (b) the premium rates for the policy are substantially increased. The benefit provided will be in the form of a Shortened Benefit Period as described below.

In addition to the contingent nonforfeiture benefit described above, if you select a limited premium payment option an additional contingent nonforfeiture benefit may also be available in the form of a reduced "paid-up" policy.

OPTIONAL RIDERS (available for an additional premium payment)

Shortened Benefit Period Nonforfeiture

The rider provides a benefit when the policy remains in force for at least 3 years and lapses due to nonpayment of premium. Coverage will continue and benefits will be payable based on the Daily Benefit in effect on the date of lapse. The new Benefit Amount payable under the rider will become equal to the greater of: (a) the total of premiums paid for the policy and all riders; or (b) 30 times the Daily Benefit in effect at the time of lapse. Any benefits paid after the policy lapses will be subtracted from this new Benefit Amount.

Full Return of Premium

The rider provides that if the policy remains in force and lapses due to your death (last of your deaths under joint coverage), the total of premiums paid will be paid to your beneficiary.

Indemnity Benefit

The rider will pay the full Daily Benefit selected for Facility Care Services and Home and Community Care Services (if covered under the policy), regardless of the actual expenses incurred by you.

Waiver of Premium

The rider will waive premiums for the policy and any attached riders after you (either insured under joint coverage) have selected and received Home and Community Care Services for 90 days (regardless of the number of visits in a day). The 90 days need not be consecutive but must be satisfied during a Single Claim Period. We will return any unearned premium to you on a pro-rata basis. Premium paid during the 90-day period described above will be considered unearned and also returned to you. The premium will be waived until you no longer satisfy the conditions on Eligibility for Payment

of Benefits (because you have recovered and you are no longer receiving Home and Community Care Services, and you are not confined in a nursing facility or assisted living facility). Premium payments will then again become due. Any new Single Claim Period will require satisfaction of a new 90-day waiting period for Waiver of Premium, as described above.

The waiting period for Waiver of Premium under the policy for confinement in a nursing facility or assisted living facility is 90 days. If you receive fewer than 90 days of Home and Community Care Services and do not qualify for Waiver of Premium under the rider, we will credit any day on which you receive Home and Community Care Services during a Single Claim Period toward satisfaction of the 90-day waiting period for Waiver of Premium under the policy.

Monthly Benefit

The rider will pay the actual Home and Community Care Services charges incurred on a monthly basis during any calendar month, up to 31 times the Daily Benefit selected for Home and Community Care Services. Benefits paid are subtracted from the Benefit Amount.

Restoration of Benefits

The rider will restore the Benefit Amount if, claims paid during a Single Claim Period have not exceeded the Benefit Amount, the policy remains in force and for a period of 180 consecutive days, you do not satisfy the conditions on Eligibility for Payment of Benefits under the policy (because you have recovered and you are not receiving any benefits). We will restore benefits up to a Maximum Benefit Amount of twice the Benefit Amount selected. Under joint coverage, if only one of you has exhausted the Maximum Benefit Amount with Restoration of Benefits, coverage will continue for the remaining insured.

Paid-up Survivor Benefit

The rider provides that the policy to which the rider is attached will be paid-up and no further premium payments will be required for the policy or any attached riders after both of the following have occurred: (a) the end of the 10th policy year; and (b) the date of death of either insured. In the event one insured dies prior to the end of the 10th policy year, the remaining insured will pay the individual premium rate that would have been charged at the original issue age and risk class for the balance of the 10-year period, after which the policy will be paid-up and no further premiums due.

Shared Benefit Amount

The rider provides a jointly Shared Benefit Amount in the event either or both joint insureds exhaust the Benefit Amount under the policy. The Shared Benefit Amount will be equal to the Benefit Amount shown on the Policy Schedule page of the policy. Benefits paid are subtracted from the Shared Benefit Amount.

First Day Home and Community Care Services Benefit

The rider will waive any Elimination Period required for Home and Community Care Services benefits. If you otherwise satisfy the Payment of Benefits provision for Home and Community Care Services, no Elimination Period will be required and benefits will be payable on the first day you are qualified to receive Home and Community Care Services benefits.

Optional Policy Surrender

The rider provides a policy surrender option after the policy has been in force for at least five years, subject to prior claim payment or current claim considerations. The surrender value will be in the form of a lump sum payment equal to 80% of the total of premium paid for the policy and any attached riders, payable upon satisfactory evidence of insurability.

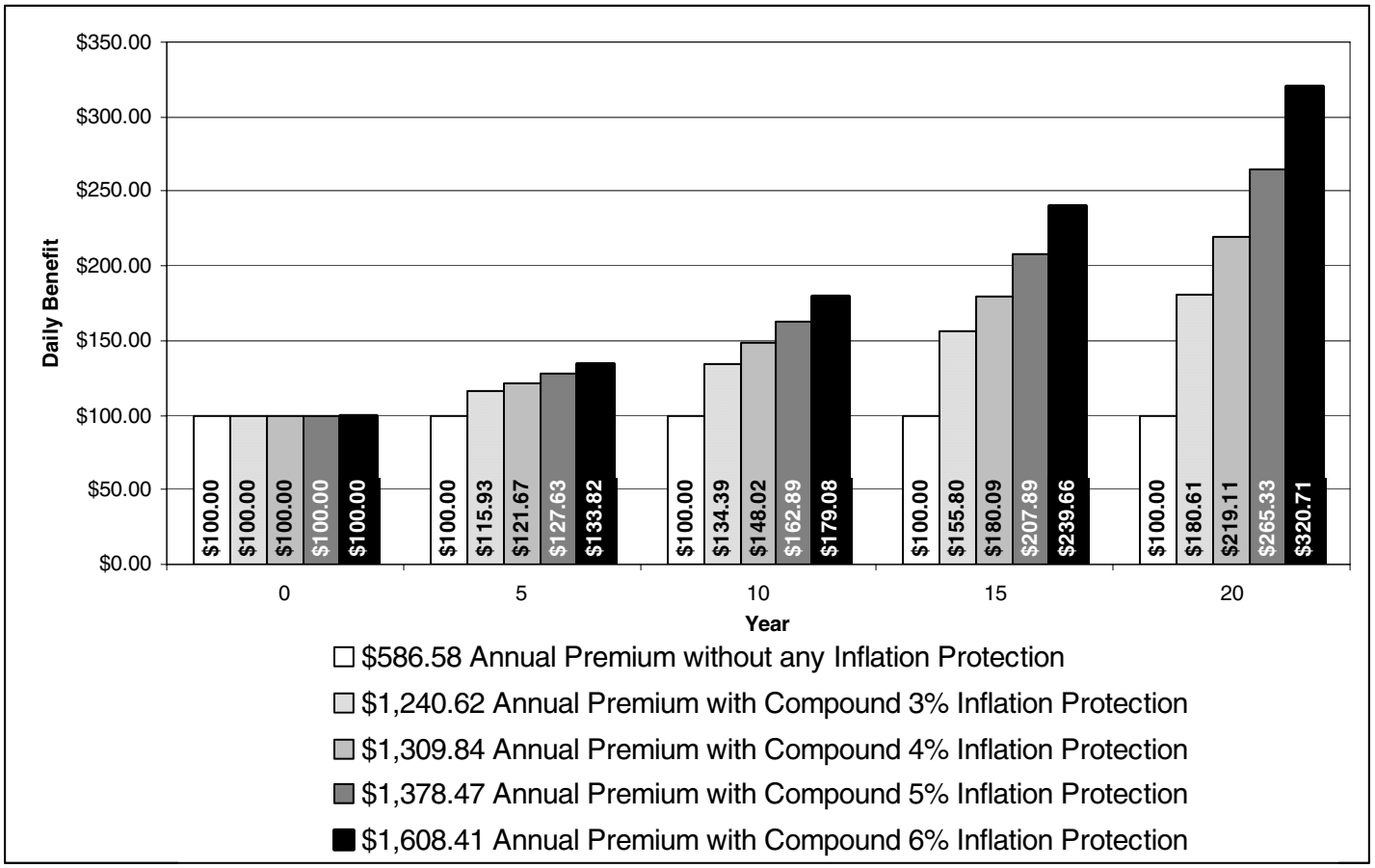
If satisfactory evidence of insurability is not provided, the surrender value will be offered as a lifetime monthly income benefit, payable until the earlier of your death (last of your deaths in the case of joint coverage) or 80% of the total of premiums paid for the policy and any attached riders has been paid to you.

Inflation Protection

The rider provides that on each policy anniversary date, we will increase the Daily Benefit and Benefit Amount payable under the policy. The Compound Inflation Protection Rider provides for optional increases of the Daily Benefit, by either 3%, 4%, 5% or 6% of the previous year's dollar amount. The remaining Benefit Amount, as well as any Shared Benefit Amount, is also increased by 3%, 4%, 5% or 6%. Under the rider, the Daily Benefit and Benefit Amount will continue to increase annually while you are receiving benefits under the policy.

Premiums for the Compound Inflation Protection Rider may be paid under either the Standard Premium or the Step Rated Premium Payment Option. If the Step Rated option is selected the premium for this rider will increase by the same amount on each policy Anniversary Date, as shown on the Policy Schedule page of the policy.

The following graph compares the benefits and premiums between a policy with a 3%, 4%, 5% and 6% Compound Inflation Protection Rider, and a policy without the rider. For purposes of illustration, the sample shown is for a policy with a 1,095-day (3-year) Benefit Period for Facility Care Services and Home and Community Care Services, issued at age 60, a 90-day Elimination Period, and a $100.00 Daily Benefit.



Agent

Address

Phone Number

CONTACT THE STATE SENIOR HEALTH INSURANCE ASSISTANCE PROGRAM IF YOU HAVE GENERAL QUESTIONS REGARDING LONG TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG TERM CARE INSURANCE POLICY.

Berkshire Life Insurance Company of America
Home Office: Pittsfield, Massachusetts
Long Term Care Administrative Office
Post Office Box 4243
Woodland Hills, CA 91365-4243
888-505-8743

APPLICATION FOR LONG TERM CARE INSURANCE

(PLEASE PRINT)

BG01A(01/09)-AR

Applicant Information

Applicant (First Name, Middle Initial, Last Name)			Sex	Birthplace (City, State)
John Doe			☒ M ☐ F	Anytown, ST
Social Security Number	**Height**	**Weight**	**Birthdate**	**Age as of Nearest Birthday**
123-45-6789	6' 0"	180	7-1-53	55
Residence Address (Street, City, State, Zip)				Phone Work: (555) 555-1212 Home: (555) 555-1212 Other: (555) 555-1212 Acceptable times to call: ☒ Day ☐ Evening ☐ Sat/Sun
123 Main St., Anytown, ST 12345-1234				
Billing Address — If different (Name, Street, City, State, Zip)				

Health Questions

1. During the past 10 years, have you been medically diagnosed with or treated for:

Yes	No			Yes	No		
☐	☒	a)	AIDS or positive HIV status?	☐	☒	e)	Multiple Sclerosis?
☐	☒	b)	Alzheimer's Disease or dementia?	☐	☒	f)	Parkinson's Disease or Parkinsonism?
☐	☒	c)	Amyotrophic Lateral Sclerosis?	☐	☒	g)	stroke?
☐	☒	d)	Hepatitis C?	☐	☒	h)	TIA (transient ischemic attack)?

2. Due to any mental or physical disability that you now have or have had in the past, is any person or institution authorized to act on your behalf?

Yes	No
☐	☒

PLEASE NOTE BEFORE YOU CONTINUE WITH THIS APPLICATION: If you answered YES to any part of Question 1 or to Question 2, we suggest that you do not submit this application. If you answered NO to every part of Question 1 and to Question 2, please continue.

3. During the past 24 months, have you:

Yes	No		
☐	☒	a)	needed assistance or supervision with dressing, eating, bathing, toileting, transferring, or walking?
☐	☒	b)	used a wheelchair, walker, brace or cane?
☐	☒	c)	used oxygen equipment, received kidney dialysis or required a catheter?
☐	☒	d)	received home health care services, physical or other rehabilitative therapy?
☐	☒	e)	experienced amnesia, confusion, forgetfulness or memory loss?
☐	☒	f)	experienced dizziness, fainting, weakness or chronic fatigue?
☐	☒	g)	experienced falling, unstable gait, paralysis or loss of balance?
☐	☒	h)	been confined to a nursing facility, assisted living facility, or home for the aged?

4. During the past 10 years, have you been medically advised or treated for:

Yes	No			Yes	No		
☐	☒	a)	high blood pressure?	☐	☒	h)	alcohol or drug dependency or abuse?
☐	☒	b)	heart disorder?	☐	☒	i)	arthritis or osteoporosis?
☐	☒	c)	circulatory disorder?	☐	☒	j)	depression or other psychiatric disorder?
☐	☒	d)	diabetes?	☐	☒	k)	breast, prostate or other genito-urinary disorder?
☐	☒	e)	emphysema or other chronic lung disorder?				
☐	☒	f)	cancer; internal or melanoma?	☐	☒	l)	glaucoma or macular degeneration?
☐	☒	g)	seizures or other neurological disorder?	☐	☒	m)	liver disease or disorder?

If you answered "Yes" to any of Questions 3-4, provide full details below. Additional details may be provided on page 4:

Ques. No.	Date From	Date To	Describe Condition and Treatment	Name of Physician or Care Facility

Berkshire Life Insurance Company of America, Pittsfield, MA is a wholly owned stock subsidiary of The Guardian Life Insurance Company of America, New York, NY.

RETURN TO LONG TERM CARE ADMINISTRATIVE OFFICE

Health Questions (continued)

5. Provide the name, address and phone number of your primary care physician (PCP). Additional details may be provided on page 4:

J. Doctor
145 Main St., Anytown, ST 12345-1234

Date last seen: 5-1-08 Reason for visit: Check-up

6. Provide the names of all medical specialists (other than your PCP) consulted within the last 2 years. Additional details may be provided on page 4:

Name / Phone number	Specialty	Reason for visit	Medication / treatment prescribed

7. During the past 12 months have you:

Yes No

❍ ☒ a) smoked cigarettes?

❍ ☒ b) received disability benefits? If "Yes," details:

❍ ☒ c) been advised to have any surgery that has not yet been performed? If "Yes," details:

❍ ☒ d) been declined by another company for a policy providing nursing home or home health care coverage? If "Yes," details:

❍ ☒ e) taken prescription medication? If "Yes," list all medications:

Additional Questions

Yes No

❍ ☒ **8. Are you actively at work? If "Yes," hours per week:**

9. Occupation: **If retired, date of retirement:**

10. With whom do you currently live? ☒ Spouse ❍ Family ❍ Alone ❍ Other:

11. Type of residence? ☒ House or Condo ❍ Apartment ❍ Retirement Community ❍ Other

Information About Your Insurance Coverage

Yes No

❍ ☒ **12. Are you covered by Medicaid? (This does not mean Medicare)**

❍ ☒ **13. Do you have a policy, certificate or application with this or any other company providing long term care insurance (including a health care service contract or health maintenance organization contract)?**

❍ ☒ **14. Did you have another long term care insurance policy or certificate in force during the last twelve (12) months?**

If that policy lapsed, when did it lapse?

❍ ☒ **15. Do you intend to replace any of your long term care, medical or health insurance coverage with this policy?**

If you answered "Yes" to any of Questions 13-15, provide full details below and complete required replacement forms. Additional details may be provided on page 4:

Ques. No.	Company	Issue Date	Type	Daily Benefit	Paid-to-Date

COMPLETE THIS PAGE FOR JOINT COVERAGE APPLICANT ONLY

Applicant Information

Applicant (First Name, Middle Initial, Last Name)			Sex	Birthplace (City, State)
Mary Doe			❍ M ☒ F	Anytown, ST
Social Security Number	**Height**	**Weight**	**Birthdate**	**Age as of Nearest Birthday**
234-56-7891	5' 5"	130 lbs.	7-1-58	50

Phone
Work: (555) 555-1212
Home: (555) 555-1212
Other: (555) 555-1212
Acceptable times to call:
☒ Day ❍ Evening ❍ Sat/Sun

Relationship to Primary Applicant: Wife

Health Questions

1. During the past 10 years, have you been medically diagnosed with or treated for:

Yes	No			Yes	No		
❍	☒	a)	AIDS or positive HIV status?	❍	☒	e)	Multiple Sclerosis?
❍	☒	b)	Alzheimer's Disease or dementia?	❍	☒	f)	Parkinson's Disease or Parkinsonism?
❍	☒	c)	Amyotrophic Lateral Sclerosis?	❍	☒	g)	stroke?
❍	☒	d)	Hepatitis C?	❍	☒	h)	TIA (transient ischemic attack)?

2. Due to any mental or physical disability that you now have or have had in the past, is any person or institution authorized to act on your behalf?

Yes	No
❍	☒

PLEASE NOTE BEFORE YOU CONTINUE WITH THIS APPLICATION: If you answered YES to any part of Question 1 or to Question 2, we suggest that you do not submit this application. If you answered NO to every part of Question 1 and to Question 2, please continue.

3. During the past 24 months, have you:

Yes	No		
❍	☒	a)	needed assistance or supervision with dressing, eating, bathing, toileting, transferring, or walking?
❍	☒	b)	used a wheelchair, walker, brace or cane?
❍	☒	c)	used oxygen equipment, received kidney dialysis or required a catheter?
❍	☒	d)	received home health care services, physical or other rehabilitative therapy?
❍	☒	e)	experienced amnesia, confusion, forgetfulness or memory loss?
❍	☒	f)	experienced dizziness, fainting, weakness or chronic fatigue?
❍	☒	g)	experienced falling, unstable gait, paralysis or loss of balance?
❍	☒	h)	been confined to a nursing facility, assisted living facility, or home for the aged?

4. During the past 10 years, have you been medically advised or treated for:

Yes	No			Yes	No		
❍	☒	a)	high blood pressure?	❍	☒	h)	alcohol or drug dependency or abuse?
❍	☒	b)	heart disorder?	❍	☒	i)	arthritis or osteoporosis?
❍	☒	c)	circulatory disorder?	❍	☒	j)	depression or other psychiatric disorder?
❍	☒	d)	diabetes?	❍	☒	k)	breast, prostate or other genito-urinary disorder?
❍	☒	e)	emphysema or other chronic lung disorder?				
❍	☒	f)	cancer; internal or melanoma?	❍	☒	l)	glaucoma or macular degeneration?
❍	☒	g)	seizures or other neurological disorder?	❍	☒	m)	liver disease or disorder?

If you answered "Yes" to any of Questions 3-4, provide full details below. Additional details may be provided on page 4:

Ques. No.	Date From	Date To	Describe Condition and Treatment	Name of Physician or Care Facility

RETURN TO LONG TERM CARE ADMINISTRATIVE OFFICE

COMPLETE THIS PAGE FOR JOINT COVERAGE APPLICANT ONLY

Health Questions (continued)

5. Provide the name, address and phone number of your primary care physician (PCP). Additional details may be provided on page 4:

J. Doctor

145 Main St., Anytown, ST 12345-1234

Date last seen: 5-1-08 Reason for visit: Check-up

6. Provide the names of all medical specialists (other than your PCP) consulted within the last 2 years. Additional details may be provided on page 4:

Name / Phone number	Specialty	Reason for visit	Medication / treatment prescribed

7. During the past 12 months have you:

Yes No

❍ ☒ a) smoked cigarettes?

❍ ☒ b) received disability benefits? If "Yes," details:

❍ ☒ c) been advised to have any surgery that has not yet been performed? If "Yes," details:

❍ ☒ d) been declined by another company for a policy providing nursing home or home health care coverage? If "Yes," details:

❍ ☒ e) taken prescription medication? If "Yes," list all medications:

Additional Questions

Yes No

❍ ☒ **8. Are you actively at work? If "Yes," hours per week:**

9. Occupation: **If retired, date of retirement:**

10. With whom do you currently live? ☒ Spouse ❍ Family ❍ Alone ❍ Other:

11. Type of residence? ☒ House or Condo ❍ Apartment ❍ Retirement Community ❍ Other

Information About Your Insurance Coverage

Yes No

❍ ☒ **12. Are you covered by Medicaid? (This does not mean Medicare)**

❍ ☒ **13. Do you have a policy, certificate or application with this or any other company providing long term care insurance (including a health care service contract or health maintenance organization contract)?**

❍ ☒ **14. Did you have another long term care insurance policy or certificate in force during the last twelve (12) months?**

If that policy lapsed, when did it lapse?

❍ ☒ **15. Do you intend to replace any of your long term care, medical or health insurance coverage with this policy?**

If you answered "Yes" to any of Questions 13-15, provide full details below and complete required replacement forms. Additional details may be provided on page 4:

Ques. No.	Company	Issue Date	Type	Daily Benefit	Paid-to-Date

Coverage Applied For

** If a PARTNERSHIP POLICY is selected below and you are age **75 or younger**, the 3%, 4%, 5% **or** 6% Compound Inflation Protection Rider must be selected and will be issued with your policy.*

☒ Partnership Policy ☐ Non-Partnership Policy

Comprehensive coverage is Facility Care Services plus Home and Community Care Services (HCCS)

Select only one of the following coverage combinations:

- ☐ Facility Care Services Only
- ☐ Facility Care Services Only with Indemnity Benefit Rider
- ☒ Comprehensive
- ☐ Comprehensive with Indemnity Benefit Rider
- ☐ Comprehensive with Monthly Benefit Rider *(the Compound Inflation Protection Rider must also be selected)*

** Refer to Partnership Policy requirements above.*

Inflation Protection Rider (select one of the following):

☐ Compound 6% ☒ Compound 5%
☐ Compound 4% ☐ Compound 3%

Daily Benefit Applied For ($50-$400): $ 150.00

Elimination Period:

☐ 0 Days ☐ 30 Days ☒ 90 Days ☐ 180 Days

Nonforfeiture Rider:

☒ Shortened Benefit Period Nonforfeiture

Benefit Extension Riders (select only one):
(not available with Lifetime Benefit Period)

- ☐ Restoration of Benefits
- ☐ Shared Benefit Amount *(available only with joint coverage)*

Additional Riders:

- ☐ Full Return of Premium
- ☐ Paid-Up Survivor *(available with joint coverage and Lifetime Premium Payment Option)*
- ☐ Optional Policy Surrender *(not available with Nonforfeiture Rider or Full Return of Premium Rider)*

The following Riders are available with Comprehensive Coverage only:

- ☐ Waiver of Premium
- ☐ First Day HCCS Benefit

Benefit Period:

☐ Lifetime ☐ 2,190 Days (6 Years) ☒ 1,825 Days (5 Years) ☐ 1,460 Days (4 Years) ☐ 1,095 Days (3 Years)

Required Benefit Rejection

** See Inflation Protection Rider requirements related to Partnership Policies above.*

If Inflation Protection or Nonforfeiture Benefits **ARE NOT SELECTED** you must initial in boxes below:

REJECTION of Inflation Protection Rider — I have reviewed the Outline of Coverage and the graph that compares the benefits and premiums of the policy with and without the Inflation Protection Rider and I have chosen to reject the rider.

Initial here: [ ] Primary Applicant [ ] Joint Applicant

REJECTION of Nonforfeiture Rider — I have reviewed the Outline of Coverage that describes the Shortened Benefit Period Nonforfeiture Rider and I have chosen to **reject** the rider.

Initial here: [ ] Primary Applicant [ ] Joint Applicant

Premium Information

Primary Applicant Rate Class:

☒ Preferred Plus ☐ Preferred ☐ Standard

Joint Applicant Rate Class:

☒ Preferred Plus ☐ Preferred ☐ Standard

Premium Payment Options (select only one):

- ☐ 10-Year Premium
- ☐ Paid-Up At Age 65 Premium **(available to age 55)**
- ☒ Lifetime Premium **(if Lifetime Premium and 5% Inflation Protection are selected, you must also select one of the following):**
  - ☐ Standard Premium Payment Option
  - ☒ Step Rated Premium Payment Option

Payment Mode and Amount (select only one):

☒ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly Automatic Payment Plan

☐ **List Billing (select mode as shown below):**

☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly

Approved Employer or Association Group?

☐ Yes ☒ No If "Yes," Group Identification Code or Name: _____

Paid with Application	**Beneficiary Name and Relationship**
$ 1,950.80	Jane Doe Sister

Special Request / Requested Effective Date

RETURN TO LONG TERM CARE ADMINISTRATIVE OFFICE

Unintentional Lapse

PROTECTION AGAINST UNINTENTIONAL LAPSE

I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long term care insurance policy for non-payment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid. **Check applicable box:**

❍ I elect NOT to designate any person to receive such notice.

☒ I designate the following person to receive notice prior to cancellation of my policy for non-payment of premium:

Name: Paul Doe Telephone Number: (555) 555-1414

Address: 123 First St. (Street) Anytown (City) ST (State) 12345-1234 (Zip Code)

Relationship: Brother

Additional Information

ADDITIONAL INFORMATION

Provide additional details for any "yes" answers, or for questions 4 and 5. Include the question number and indicate whether details pertain to **Primary** or **Joint** Applicant.

Representations of the Applicant(s)

CAUTION: If your answers on this application are incorrect or untrue, Berkshire Life Insurance Company of America may have the right to deny benefits or rescind your policy.

Those parties who sign below agree and acknowledge that:

1. This application and any other supplements to the application will form the basis for, and become part of and attached to, any policy issued.
2. All of the statements that are part of the application and any other supplements to the application are correctly recorded, and are complete and true to the best of the knowledge and belief of those persons who made them.
3. No agent, broker or medical examiner has any right to accept risks, make or change contracts, or to waive or modify any of Berkshire Life Insurance Company of America's rights or requirements.
4. The Effective Date of the Policy is the date from which premiums are calculated and become due. No insurance shall take effect unless and until this application is approved by Berkshire Life Insurance Company of America, a policy is issued during the lifetime of the applicant(s), the initial premium payment has been made and, as of the Effective Date of the Policy, the health status of the applicant(s) remains insurable under Berkshire Life Insurance Company of America's underwriting standards.
5. By paying premiums on a basis more frequently than annually, the total premium payable during one year's time will be greater than if the premium were paid annually. That is, the cost of paying annualized periodic premiums will be more than the cost of paying one annual premium.
6. I have received an Outline of Coverage, NAIC Shopper's Guide, Disclosure Statement including Notice of Insurance Information Practices, Potential Rate Increase Disclosure Form, and Notice of Privacy Practices.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signatures

Signed at Anytown, ST (City and State) this 1st (Day) day of August (Month), 2008 (Year).

✘ John Doe
Signature of Applicant

✘ Mary Doe
Signature of Joint Applicant

RETURN TO LONG TERM CARE ADMINISTRATIVE OFFICE

Berkshire Life Insurance Company of America
Home Office: Pittsfield, Massachusetts
Long Term Care Administrative Office
Post Office Box 4243
Woodland Hills, CA 91365-4243
888-505-8743

APPLICATION FOR LONG TERM CARE INSURANCE

(PLEASE PRINT)

BG01SA(01/09)-AR

Applicant (First Name, Middle Initial, Last Name)			Sex	Birthplace (City, State)
John Doe			☒ M ☐ F	Anytown, ST
Social Security Number	**Height**	**Weight**	**Birthdate**	**Age as of Nearest Birthday**
123-45-6789	6'0"	180	7-1-53	55
Residence Address (Street, City, State, Zip)				Work Phone: (555) 555-1212 Home Phone: (555) 555-1212 Cell/Other: (555) 555-1212 Best time to reach: ☒ Day ☐ Evening ☐ Sat/Sun
123 Main St., Anytown, ST 12345-1234				

1. During the past 10 years, have you been medically diagnosed with or treated for:
   a) AIDS or positive HIV status? ☐ **Yes** ☒ **No**
   b) Alzheimer's Disease, dementia, or chronic permanent memory loss? ☐ **Yes** ☒ **No**
   c) Amyotrophic Lateral Sclerosis? ☐ **Yes** ☒ **No**
   d) Hepatitis C? ☐ **Yes** ☒ **No**
   e) Multiple Sclerosis? ☐ **Yes** ☒ **No**
   f) Parkinson's Disease or Parkinsonism? ☐ **Yes** ☒ **No**
   g) any permanent paralysis? ☐ **Yes** ☒ **No**
2. Are you covered by Medicaid? (This does not mean Medicare) ☐ **Yes** ☒ **No**

IF YOU ANSWERED "YES" TO QUESTION 1 OR 2 ABOVE, YOU ARE NOT ELIGIBLE FOR THIS PROGRAM - DO NOT COMPLETE OR SUBMIT THIS APPLICATION.

3. Provide the name, address and phone number of your primary care physician: J. Doctor
   145 Main St., Anytown, ST 12345-1234
   Date last seen: 5-1-08 Reason for visit: Check-up
4. During the past 12 months have you:
   a) smoked cigarettes? ☐ **Yes** ☒ **No**
   b) received disability benefits? ☐ **Yes** ☒ **No** If "Yes," details: _____
   c) taken prescription medications? ☐ **Yes** ☒ **No** If "Yes," list all medications: _____
5. Are you actively working? ☒ **Yes** ☐ **No** If "Yes," hours per week: 40 Occupation: Attorney
6. Group Name: AAA Legal Services Group ID: 12345
7. Are you applying for joint coverage? ☐ **Yes** ☒ **No**
   If "Yes," indicate the name of the joint applicant: _____ and complete separate application.
8. Do you have a policy, certificate or application with this or any other company providing long term care insurance (including a health care service contract or health maintenance organization contract)? ☐ **Yes** ☒ **No**
9. Did you have another long term care insurance policy or certificate in force during the last twelve (12) months? ☐ **Yes** ☒ **No**
   If that policy lapsed, when did it lapse? _____
10. Do you intend to replace any of your long term care, medical or health insurance coverage with this policy? ☐ **Yes** ☒ **No**

If you answered "Yes" to any of Questions 8-10, provide full details below and complete required replacement forms:

Ques. No.	Company	Issue Date	Type of Policy	Daily Benefit	Paid-to-Date

Beneficiary Name and Relationship	Special Request
Jane Doe Sister	

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Berkshire Life Insurance Company of America, Pittsfield, MA is a wholly owned stock subsidiary of The Guardian Life Insurance Company of America, New York, NY.

RETURN TO LONG TERM CARE ADMINISTRATIVE OFFICE

PROTECTION AGAINST UNINTENTIONAL LAPSE

I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long term care insurance policy for nonpayment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid. **Check applicable box:**

❍ I elect NOT to designate any person to receive such notice.

☒ I designate the following person to receive notice prior to cancellation of my policy for nonpayment of premium:

Name: Paul Doe Telephone Number: (555) 555-1414

Address: 123 First St. (Street) Anytown (City) ST (State) 12345-1234 (Zip Code)

Relationship: Brother

NOTICE OF INSURANCE INFORMATION PRACTICES - To evaluate your application, we will need some personal information about you. It may be necessary to obtain some of that information from sources other than yourself. For your protection, you have a qualified right to learn what information we obtain about you. You also have the right to request correction of any erroneous information. The information we obtain about you will be used by Berkshire Life Insurance Company of America to determine eligibility for insurance and/or benefits under an existing policy and for other business purposes in connection with the insurance relationship. The information obtained may not be released to any person or organization except to reinsuring companies, any third party administrators designated by Berkshire Life Insurance Company of America or other persons or organizations performing services in connection with your application, claim or as may be otherwise lawfully required or as you may further authorize. We will furnish a more detailed summary of our information practices upon request.

CAUTION: If your answers on this application are incorrect or untrue, Berkshire Life Insurance Company of America may have the right to deny benefits or rescind your policy.

AGREEMENT - The answers given are complete and true to the best of my knowledge and belief. I understand that the Company will rely on my written answers to the questions in this application and that if my answers are not complete and true, my policy may not be valid. I understand that the agent cannot determine eligibility for or alter the terms of the proposed policy. I also understand that submission of this application does not place any insurance coverage in force.

ACKNOWLEDGMENT - I acknowledge receipt of an Outline of Coverage, NAIC Shopper's Guide, Notice of Insurance Information Practices, Potential Rate Increase Disclosure Form, and Notice of Privacy Practices.

AUTHORIZATION FOR DISCLOSURE, RECEIPT AND USE OF PERSONAL HEALTH INFORMATION -

☒ Complete and submit BG01AUT(06/05) with this application.

*If a PARTNERSHIP POLICY is selected below and you are age **75 or younger**, the 3%, 4%, 5% **or** 6% Compound Inflation Protection Rider must be selected and will be issued with your policy.* ☒ Partnership Policy ❍ Non-Partnership Policy

REJECTION OF INFLATION PROTECTION RIDER - I have reviewed the Outline of Coverage and the graph that compares the benefits and premiums of the policy with and without the Inflation Protection Rider and I have chosen to **reject** the rider.

Initial here: ☐

REJECTION OF NONFORFEITURE RIDER - I have reviewed the Outline of Coverage that describes the Shortened Benefit Period Nonforfeiture Rider and I have chosen to **reject** the rider.

Initial here: ☐

Signed at: Anytown, ST (City, State) ✘ John Doe (Applicant's Signature) 8-1-08 (Date)

AGENT'S CERTIFICATION

1. To the best of your knowledge, is the insurance applied for intended to replace any long term care, medical or health insurance in force with this or any other company? ❍ **Yes** ☒ **No**
2. List any other health insurance policies that you have sold to the applicant:

   (a) Which of the policies listed above are still in force, if any?

   (b) Which of the policies listed above sold in the past five (5) years are no longer in force, if any?
3. Did you deliver to the applicant the Outline of Coverage, the required disclosures, including the Notice of Insurance Information Practices, the NAIC Shopper's Guide and the Notice of Privacy Practices? ☒ **Yes** ❍ **No**

I represent that to the best of my knowledge and belief the information provided in the application is complete, accurate and correctly recorded; and there is nothing adversely affecting the insurability of the applicant other than as indicated in the application. I have reviewed the current health insurance coverage of the applicant and find that the coverage of the type and amount applied for is appropriate for the needs of the applicant.

John Q. Porter (Type or Print Agent's Name) ✘ John Q. Porter (Signature of Soliciting Agent)

8-1-08 (Date) 1234 (Soliciting Agent's Code) 987-65-4321 (Soliciting Agent's Social Security Number)

Berkshire Life Insurance Company of America
Home Office: Pittsfield, Massachusetts
Long Term Care Administrative Office
Post Office Box 4243
Woodland Hills, CA 91365-4243
888-505-8743

Step Rated Premium
Payment Option Disclosure

You have elected to pay the premiums for the 5% Compound Inflation Protection Rider under the Step Rated Premium Payment Option. Under this option, the annual premium for your policy will increase by the same amount on each policy Anniversary Date for the life of the policy. This amount will be shown on the Policy Schedule page of the policy. The Step Rated Premium structure cannot be changed to a Standard Premium structure during the lifetime of the policy.

I (we) have read, understand and agree to the terms and conditions of the Step Rated Premium Payment Option as described above.

Applicant's Name (please print)	Signature of Applicant	Date
Joint Applicant's Name (please print)	Signature of Joint Applicant	Date
Type or Print Agent's Name	Signature of Soliciting Agent	Date
Soliciting Agent's Code		

Berkshire Life Insurance Company of America
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Important Information Regarding Your Policy's Long-Term Care Insurance Partnership Status

This disclosure notice is issued in conjunction with your long-term care policy:

Some long-term care insurance policies sold in Arkansas qualify for the Arkansas Long-Term Care Insurance Partnership Program. Insurance companies voluntarily agree to participate in the Partnership Program by offering long-term care insurance coverage that meets certain State and Federal requirements. Long-term care insurance policies that qualify as Partnership Policies may be entitled to special treatment, and in particular an "Asset Disregard," under Arkansas's Medicaid program.

Asset Disregard means that an amount of the policyholder's assets equal to the amount of long-term care insurance benefits received under a qualified Partnership Policy will be disregarded for the purpose of determining the insured's eligibility for Medicaid. This generally allows a person to keep assets equal to the insurance benefits received under a qualified Partnership Policy without affecting the person's eligibility for Medicaid. All other Medicaid eligibility criteria will apply. Asset Disregard is not available under a long-term care insurance policy that is not a Partnership Policy. **The purchase of a Partnership Policy does not automatically qualify you for Medicaid.**

Partnership Policy Status. **Your long-term care insurance policy is intended to qualify as a Partnership Policy under the Arkansas Long-Term Care Partnership Program as of your Policy's effective date.**

What Could Disqualify Your Policy as a Partnership Policy? If you make any changes to your policy, such changes could affect whether your policy continues to be a Partnership Policy. ***Before you make any changes, you should consult with Berkshire Life Insurance Company of America to determine the effect of a proposed change.*** In addition, if you move to a State that does not maintain a Partnership Program or does not recognize your policy as a Partnership Policy, you would not receive beneficial treatment of your policy under the Medicaid program of that State. The information contained in this Notice is based on current State and Federal laws. These laws may be subject to change. Any change in law could reduce or eliminate the beneficial treatment of your policy under Arkansas's Medicaid program.

Additional Information. If you have questions regarding your insurance policy please contact Berkshire Life Insurance Company of America. If you have questions regarding current laws governing Medicaid eligibility, you should contact the Arkansas Department of Human Services.

This form and all benefit statements received should be kept with your policy.

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Important Consumer Information Regarding the Arkansas Long-Term Care Insurance Partnership Program

Some long-term care insurance policies sold in Arkansas may qualify for the Arkansas Long-Term Care Insurance Partnership Program (the Partnership Program). The Partnership Program is a partnership between state government and private insurance companies to assist individuals in planning their long-term care needs. Insurance companies voluntarily agree to participate in the Partnership Program by offering long-term care insurance coverage that meets certain State and Federal requirements. Long-term care insurance policies that qualify as Partnership Policies may protect the policyholder's assets through a feature known as "Asset Disregard" under Arkansas Medicaid program.

Asset Disregard means that an amount of the policyholder's assets equal to the amount of long-term care insurance benefits received under a qualified Partnership Policy will be disregarded for the purpose of determining the insured's eligibility for Medicaid. This generally allows a person to keep assets equal to the insurance benefits received under a qualified Partnership Policy without affecting the person's eligibility for Medicaid. All other Medicaid eligibility criteria will apply. Asset Disregard is not available under a long-term care insurance policy that is not a Partnership Policy. Therefore, you should consider whether Asset Disregard is important to you, and whether a Partnership Policy meets your needs. ***The purchase of a Partnership Policy does not automatically qualify you for Medicaid.***

What are the Requirements for a Partnership Policy. In order for a policy to qualify as a Partnership Policy, it must, among other requirements:

- be issued to an individual after January 1, 2008;
- cover an individual who was an Arkansas resident when coverage first becomes effective under the policy;
- be a tax-qualified policy under Section 7702(B)(b) of the Internal Revenue Code of 1986;
- meet stringent consumer protection standards; and,
- must provide annual inflation protection for ages 75 and younger.

If you apply and are approved for long-term care insurance coverage, Berkshire Life Insurance Company of America will provide you with written documentation as to whether your policy qualifies as a Partnership Policy.

What Could Disqualify a Policy as a Partnership Policy? Certain types of changes to a Partnership Policy could affect whether such policy continues to be a Partnership Policy. If you purchase a Partnership Policy and later decide to make *any* changes, you should first consult with Berkshire Life Insurance Company of America to determine the effect of a proposed change. In addition, if you move to a state that does not maintain a Partnership Program or does not recognize your policy as a Partnership Policy, you would not receive beneficial treatment of your policy under the Medicaid program of that state. The information contained in this disclosure is based on current Arkansas and Federal laws. These laws may be subject to change. Any change in law could reduce or eliminate the beneficial treatment of your policy under Arkansas's Medicaid program.

Additional Information. If you have questions regarding long-term care insurance policies please contact Berkshire Life Insurance Company of America. If you have questions regarding current laws governing Medicaid eligibility, you should contact the Arkansas Department of Human Services.

SERFF Tracking Number:	*LFCR-125795796*	*State:*	*Arkansas*
Filing Company:	*Berkshire Life Insurance Company of America*	*State Tracking Number:*	*40106*
Company Tracking Number:	*BG01 2008 ENHANCEMENTS AR*		
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*Care ProVider*		
Project Name/Number:	*/*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*LFCR-125795796*	*State:*	*Arkansas*
Filing Company:	*Berkshire Life Insurance Company of America*	*State Tracking Number:*	*40106*
Company Tracking Number:	*BG01 2008 ENHANCEMENTS AR*		
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*Care ProVider*		
Project Name/Number:	*/*		

Supporting Document Schedules

Review Status:

Satisfied -Name: Certification/Notice 08/28/2008
Comments:
Attachment:
AR CERTIFICATION OF COMPLIANCE.pdf

Review Status:

Bypassed -Name: Application 08/28/2008
Bypass Reason: See Form Schedule
Comments:

Review Status:

Bypassed -Name: Health - Actuarial Justification 08/28/2008
Bypass Reason: See Rate/Rule Schedule
Comments:

Review Status:

Bypassed -Name: Outline of Coverage 08/28/2008
Bypass Reason: See Form Schedule
Comments:

Review Status:

Satisfied -Name: Cover Sheet 08/28/2008
Comments:
Attachment:
BG 2008 Enhancement Cover Sheet - AR.pdf

Review Status:

Satisfied -Name: Flesch Score Certification 08/28/2008
Comments:
Attachment:
BG 2008 Enhancement Flesch Certification - AR.pdf

SERFF Tracking Number:	*LFCR-125795796*	*State:*	*Arkansas*
Filing Company:	*Berkshire Life Insurance Company of America*	*State Tracking Number:*	*40106*
Company Tracking Number:	*BG01 2008 ENHANCEMENTS AR*		
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*Care ProVider*		
Project Name/Number:	*/*		

Review Status:

Satisfied -Name: Benefit Schedule 08/28/2008

Comments:

Attachment:

BG 2008 Enhancement Benefit Schedule AR.pdf

Review Status:

Satisfied -Name: Previously Approved Forms With New Numbers 08/28/2008

Comments:

Previously approved forms with new numbersfor new policyholders

Attachments:

BG01P(01-09)-AR.pdf
BG01R-IND(01-09).pdf
BG01R-WOP(01-09).pdf
BG01R-ROB(01-09).pdf
BG01E-10P(01-09).pdf
BG01E-P65(01-09).pdf

Review Status:

Satisfied -Name: Previously Approved Forms For Use With This Product 08/28/2008

Comments:

Attachments:

BG01R-SBN(06-04).pdf
BG01R-MTH(06-04).pdf
BG01R-SVR(06-04).pdf
BG01AC(06-04).pdf
BG01AD(06-04).pdf
BG01AO(06-04).pdf
BG01AUT(06-05).pdf
BG01N-MED(06-04).pdf
BG01N-REP(06-04).pdf
BG01E-CNF(06-04).pdf
BG02E-CNF(04-07).pdf

SERFF Tracking Number:	*LFCR-125795796*	*State:*	*Arkansas*
Filing Company:	*Berkshire Life Insurance Company of America*	*State Tracking Number:*	*40106*
Company Tracking Number:	*BG01 2008 ENHANCEMENTS AR*		
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*Care ProVider*		
Project Name/Number:	*/*		

BG01WRK(06-04).pdf
BG01N-LTC(04-07).pdf
BG02N-PRI(04-07).pdf
BG01E-RED(04-07).pdf
Suitability Letter.pdf

SERFF Tracking Number:	*LFCR-125795796*	*State:*	*Arkansas*
Filing Company:	*Berkshire Life Insurance Company of America*	*State Tracking Number:*	*40106*
Company Tracking Number:	*BG01 2008 ENHANCEMENTS AR*		
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*Care ProVider*		
Project Name/Number:	*/*		

Review Status:

Satisfied -Name: AR Issuer Certification Form 11/06/2008

Comments:

Attachment:

AR Issuer Certification Form.pdf

CERTIFICATION OF COMPLIANCE

Insurer: Berkshire Life Insurance Company of America

The company has reviewed the enclosed policy form(s) and certified that they comply with the provision of Regulation 19 as well as all applicable requirements of the Arkansas Department of Insurance.

Signature: Amy Ota

Name: Amy Ota

Title: Compliance Analyst

Date: August 27, 2008

FORM FILING COVER SHEET

POLICY FORMS FILED FOR USE AS **QUALIFIED TAX STATUS:**

NEW PRODUCT ENHANCEMENTS:

BG01R-IP(01/09)	Compound Inflation Protection Rider (3%, 4%, 5%, and 6% options)
BG01R-FROP(01/09)	Full Return of Premium Rider
BG01R-OPS(01/09)	Optional Policy Surrender Rider
BG01R-FDC(01/09)	First Day HCCS Benefit Rider
BG01R-SBA(01/09)	Shared Benefit Amount Rider
BG01OC(01/09)-AR	Outline of Coverage for Long Term Care Insurance Policy
BG01A(01/09)-AR	Application for Long Term Care Insurance
BG01SA(01/09)-AR	Simplified Worksite Application
BG01D-SRP(01/09)	Step Rated Premium Payment Disclosure
BG01D-PRT(01/09)-AR	Partnership Disclosure Notice
BG01N-PRT(01/09)-AR	Partnership Program Notice

PREVIOUSLY APPROVED FORMS WITH REVISED RATES FOR NEW POLICYHOLDERS
(Form number has been updated to accommodate new rates):

BG01P(01/09)-AR	Long Term Care Insurance Policy
BG01R-IND(01/09)	Indemnity Benefit Rider
BG01R-WOP(01/09)	Waiver of Premium Rider
BG01R-ROB(01/09)	Restoration of Benefits Rider
BG01E-10P(01/09)	10-Year Premium Payment Endorsement
BG01E-P65(01/09)	Paid-Up at Age 65 Endorsement
	Actuarial Memorandum

PREVIOUSLY APPROVED FORMS FOR USE WITH THIS PRODUCT:
The rates for the following three riders were previously approved - issue ages have been expanded

BG01R-SBN(06/04)	Shortened Benefit Nonforfeiture Rider
BG01R-MTH(06/04)	Monthly Benefit Rider
BG01R-SVR(06/04)	Paid-Up Survivor Benefit Rider
BG01AC(06/04)	Agent Certification (will be required with each application)
BG01AD(06/04)	Disclosure/Conditions of Coverage
BG01AO(06/04)	Supplemental Application for Policy Ownership
BG01AUT(06/05)	Authorization (approved 7/15/08)
BG01N-MED(06/04)	Medicare Notice
BG01N-REP(06/04)	Replacement Notice
BG01E-CNF(06/04)	Contingent Benefit Upon Lapse Endorsement
BG02E-CNF(04/07)	Contingent Benefit Upon Lapse Endorsement for Limited Pay Policy (approved 8/22/08)
BG01WRK(06/04)	Long Term Care Insurance Personal Worksheet
BG01N-LTC(04/07)	Things You Should Know Before You Buy Long Term Care Insurance (approved 8/22/08)
BG02N-PRI(04/07)	Potential Rate Increase Disclosure (approved 8/22/08)
BG01E-RED(04/07)	Lowering Premiums by Reducing Benefits Endorsement (approved 8/22/08)
Sample	Long Term Care Suitability Letter

FLESCH SCALE CERTIFICATE

NEW PRODUCT ENHANCEMENTS:

FORM NUMBER:	BG01R-IP(01/09)	Compound Inflation Protection Rider
	BG01R-FROP(01/09)	Full Return of Premium Rider
	BG01R-OPS(01/09)	Optional Policy Surrender Rider
	BG01R-FDC(01/09)	First Day HCCS Benefit Rider
	BG01R-SBA(01/09)	Shared Benefit Amount Rider

PREVIOUSLY APPROVED FORMS WITH REVISED RATES FOR NEW POLICYHOLDERS (Form number has been updated to accommodate new rates)

BG01P(01/09)-AR	Long Term Care Insurance Policy
BG01R-IND(01/09)	Indemnity Benefit Rider
BG01R-WOP(01/09)	Waiver or Premium Rider
BG01R-ROB(01/09)	Restoration of Benefits Rider

PREVIOUSLY APPROVED FORMS/RATES – Issue ages expanded

BG01R-SBN(06/04)	Shortened Benefit Period Nonforfeiture Rider
BG01R-MTH(06/04)	Monthly Benefit Rider
BG01R-SVR(06/04)	Paid-Up Survivor Benefit Rider

NUMBER OF WORDS:
(**X**) 10,000 or less. Entire forms were analyzed
( ) More than 10,000 words. 200 word samples per page were analyzed.

Berkshire Life Insurance Company of America certifies that a Flesch Scale Readability test has been applied to the above forms. The score for each form is as follows:

BG01P(01/09)-AR 54
BG01R-SBN(06/04)…… 55
BG01R-IND(01/09) 58
BG01R-WOP(01/09)…….51
BG01R-MTH(06/04)……..61
BG01R-ROB(01/09)……..51
BG01R-SVR(06/04)……..65
BG01R-IP(01/09)……..55
BG01R-FROP(01/09)…..……..59
BG01R-OPS(01/09)…….…….53
BG01R-FDC(01/09)……..58
BG01R-SBA(01/09)……..53

Laura H. Rotenberg

Laura H. Rotenberg
Second Vice President and Counsel

July 15, 2008

POLICY SCHEDULE

POLICY INFORMATION

Policy Number:	15-12345678		
Insured:	John Doe	Insuring Age:	55
Insured:	Mary Doe	Insuring Age:	50

POLICY FORMS	EFFECTIVE DATE	PREMIUM
Long Term Care Insurance Policy, BG01P(01/09)-AR	1/1/09	$1,050.85
Compound Inflation Protection Rider, BG01R-IP(01/09)	1/1/09	$557.37
Percentage Increase Rate: 5% (with Step Rated Premium Payment Option)		
Shortened Benefit Period Nonforfeiture Rider, BG01R-SBN(06/04)	1/1/09	$342.58
Total Joint Annual Premium:* (see notes 1 and 2 below)		$1,950.80

Total Individual Annual Premium Insuring Age 55 - $1,625.67

Total Individual Annual Premium Insuring Age 50 - $1,280.37

1. If you choose a:

   Semi-Annual Premium you will pay $1,014.42 every 6 months. This means you are paying an additional $78.03 or 4.0% per year, or a total annualized premium of $2,028.83.

   Quarterly Premium you will pay $526.72 every 3 months. This means you are paying an additional $156.06 or 8.0% per year, or a total annualized premium of $2,106.86.

   Monthly Premium you will pay $171.67 every month. This means you are paying an additional $109.24 or 5.6% per year, or a total annualized premium of $2,060.04.

2. The Total Joint Annual Premium will be increased on each Anniversary Date shown below due to the Step Rated Premium Payment Option for the Compound Benefit Increase Rider. Refer to the attached Step Rated Premium Increase Schedule.

Premium Payment Period: Lifetime

Anniversary Date: 1/1/10 and each succeeding 1/1 thereafter.

Policy Schedule Date: 1/1/09

This Policy Schedule replaces any previously issued Policy Schedules.

Policy Number:	15-12345678
Insured:	John Doe
Insured:	Mary Doe

BENEFIT INFORMATION

All Benefits, the Elimination Period and the Benefit Amount shown below apply individually to each Insured named above.

Elimination Period:	90 Days
Benefit Period:	5 Years
Daily Benefit for Facility Care Services (in a Nursing Facility or Assisted Living Facility) up to:	$150.00
Daily Benefit for Home and Community Care Services up to:	$150.00
Monthly Benefit for Emergency Response System: up to	$50.00
Maximum Lifetime Caregiver Training: up to	$450.00
Maximum Lifetime Alternative Plan of Care: up to	$7,500.00
Facility Bed Reservation: up to	30 days per calendar year
Respite Care Services: up to	30 days per calendar year
Coverage outside the United States, or its territories, or Canada: up to	30 days per calendar year
Benefit Amount payable:	$273,750.00

Daily Benefit of $150.00 times Benefit Period of 1,825 days(5 years)

Our toll-free number for policy service and claims is 888-505-8743.

STEP RATED PREMIUM INCREASE SCHEDULE

Premiums

	Annual	Semi-Annual	Quarterly	Monthly
Modal increase on each succeeding Anniversary Date:	$139.34	$72.46	$37.62	$12.54
9/1/2009	2,090.14	1,086.87	564.34	188.11
9/1/2010	2,229.48	1,159.33	601.96	200.65
9/1/2011	2,368.82	1,231.79	639.58	213.19
9/1/2012	2,508.16	1,304.24	677.20	225.73
9/1/2013	2,647.50	1,376.70	714.83	238.28
9/1/2014	2,786.84	1,449.16	752.45	250.82
9/1/2015	2,926.18	1,521.61	790.07	263.36
9/1/2016	3,065.52	1,594.07	827.69	275.90
9/1/2017	3,204.86	1,666.53	865.31	288.44
9/1/2018	3,344.20	1,738.98	902.93	300.98
9/1/2019	3,483.54	1,811.44	940.56	313.52
9/1/2020	3,622.88	1,883.90	978.18	326.06
9/1/2021	3,762.22	1,956.35	1,015.80	338.60
9/1/2022	3,901.56	2,028.81	1,053.42	351.14
9/1/2023	4,040.90	2,101.27	1,091.04	363.68
9/1/2024	4,180.24	2,173.72	1,128.66	376.22
9/1/2025	4,319.58	2,246.18	1,166.29	388.76
9/1/2026	4,458.92	2,318.64	1,203.91	401.30
9/1/2027	4,598.26	2,391.10	1,241.53	413.84
9/1/2028	4,737.60	2,463.55	1,279.15	426.38
9/1/2029	4,876.94	2,536.01	1,316.77	438.92
9/1/2030	5,016.28	2,608.47	1,354.40	451.47
9/1/2031	5,155.62	2,680.92	1,392.02	464.01
9/1/2032	5,294.96	2,753.38	1,429.64	476.55
9/1/2033*	5,434.30	2,825.84	1,467.26	489.09

* Premium increases will continue on each Anniversary Date for the life of the Policy

Berkshire Life Insurance Company of America
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Long Term Care Administrative Office
Post Office Box 4243
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888-505-8743

LONG TERM CARE INSURANCE POLICY

Non-Participating

READ THIS POLICY CAREFULLY. It is a legal contract between you and us.

THIS POLICY IS INTENDED TO BE A FEDERALLY TAX-QUALIFIED LONG TERM CARE INSURANCE CONTRACT AS DEFINED UNDER SECTION 7702B(b) OF THE INTERNAL REVENUE CODE OF 1986, as amended, and will be endorsed to conform to changes in that definition. You should consult with your attorney, accountant, or tax advisor regarding the tax implications of purchasing this long term care insurance.

INSURING AGREEMENT AND EFFECTIVE DATE: Subject to the terms and conditions described in this Policy, Berkshire Life Insurance Company of America agrees to pay to you the benefits described in this Policy. We make this agreement and issue this Policy in consideration of: (1) the statements made in your signed application, which is attached to and made a part of this Policy; and (2) payment of the initial premium. This Policy takes effect on the Effective Date shown on the Policy Schedule.

NOTICE TO BUYER: **Should you have any questions about your insurance, contact us at our Administrative Office shown above or call the Policyholder Service Department at (888) 505-8743. If you are not satisfied, you may contact the Arkansas Department of Insurance, Consumer Services Division, at 1200 W. Third Street, Little Rock, AR 72201 1904 (800) 852-5494 or (501) 371-2640.**

This Policy may not cover all of the costs associated with long term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all Policy limitations. No prior hospital confinement is required in order to qualify for benefits under this Policy and attached Riders, if any.

CAUTION: **The issuance of this Long Term Care Insurance Policy is based upon your responses to the questions on your application. A copy of your application is enclosed. If responses are incorrect or untrue, we may have the right to deny benefits or rescind your Policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact us at the address shown above.**

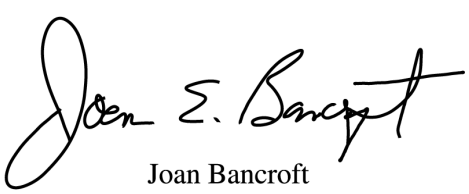
THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY: If you are eligible for Medicare, review the "Guide to Health Insurance for People with Medicare" available from us.

THIS POLICY IS GUARANTEED RENEWABLE FOR LIFE: To renew, pay the premium due by the Premium Due Date or within the Grace Period. We cannot cancel or refuse to renew this Policy. Premiums are subject to change. We can only change the premium for this Policy if we change premiums for everyone in your state with the same Policy form. We will give you at least 60 days written notice at your last address shown in our records before we change your premium.

FREE LOOK PERIOD FOR 30 DAYS: If you are not satisfied with this Policy, you may return it to us or any authorized agent or agency within 30 days from the date you receive it. We will then refund any premium you have paid and this Policy, all riders and attachments will be considered never to have been in effect.

Executed for the Company at its Home Office in Pittsfield, Massachusetts.

John P. Cifu
Secretary



Joan Bancroft
President

Berkshire Life Insurance Company of America, Pittsfield, MA is a wholly owned stock subsidiary of The Guardian Life Insurance Company of America, New York, NY.

POLICY GUIDE

POLICY DEFINITIONS

Activities of Daily Living:

- Bathing: Washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.
- Continence: The ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).
- Dressing: Putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.
- Eating: Feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.
- Toileting: Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
- Transferring: Moving into or out of a bed, chair, or wheelchair.

Adult Day Care means a program of services provided to Chronically Ill individuals during the day in a community group setting through an Adult Day Care Center that includes:

- social and health-related services; and
- Maintenance or Personal Care Services.

The purpose of such a program is to support frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the home.

Adult Day Care Center means a facility licensed or certified under state law, if any, to provide Adult Day Care to adults who do not require 24-hour institutional care, but are not capable of full-time, independent living.

Assisted Living Facility means a place which:

- is licensed or certified under state law to perform the services it is providing, where such licensing or certification is required;
- has at least one trained staff member on duty 24-hours per day;
- provides continuous room and board; and
- provides Maintenance or Personal Care Services required by residents due to their inability to perform the Activities of Daily Living or due to a Severe Cognitive Impairment.

Assisted Living Facilities do not include Hospitals. Unless otherwise excluded in this Policy, Assisted Living Facilities include facilities otherwise named, which meet the above criteria, including secure Alzheimer's units.

Caregiver Training means training provided by a health care professional, approved by us, to an informal caregiver. The informal caregiver may be an unpaid member of your Family, a friend or neighbor. Examples of such training may include, but are not limited to:

- the proper care and use of medical devices such as catheters, intravenous medications, colostomy bags or suctioning tubes;
- assistance with medications, bandages and dressings; or
- the proper performance of various procedures to assist you with your Activities of Daily Living.

Caregiver Training is provided in a setting other than a Hospital, Nursing Facility or Assisted Living Facility.

Chronically Ill means that within the previous 12 months you have been certified by a Licensed Health Care Practitioner as:

- being unable to perform, without Substantial Assistance, at least two Activities of Daily Living for a period of at least 90 days due to loss of functional capacity; or
- having a Severe Cognitive Impairment.

Effective Date means the date coverage under this Policy and any attached riders is first in force. This date is shown on the Policy Schedule.

Elimination Period means the number of days on which you satisfy the conditions on Eligibility for Payment of Benefits and receive either Facility Care Services or Home and Community Care Services (if covered under this Policy), as defined in this Policy, before we will begin paying benefits. Your Elimination Period is shown on the Policy Schedule. Each day of covered services under this Policy counts towards your Elimination Period, unless otherwise noted. Once you have satisfied the Elimination Period, no future Elimination Period is required. Days may be accumulated under separate claims in order to satisfy the Elimination Period. The Elimination Period applies to each insured individually under joint coverage.

The Elimination Period is not applicable to Caregiver Training or Respite Care Services. Use of these benefits does not count toward satisfaction of the Elimination Period for any other benefits payable under this Policy.

Facility Care Services means:

- Qualified Long Term Care Services provided to you in a Nursing Facility or Assisted Living Facility; or
- Maintenance or Personal Care Services performed in an Assisted Living Facility.

Family means you or your spouse and those related to you or your spouse; including a parent, sibling, child, grandparent or grandchild (including any of his or her in-laws, step or legally adopted relatives).

Hands-On Assistance means the physical assistance of another person without which you would be unable to perform the Activity of Daily Living.

Home and Community Care Services means Qualified Long Term Care Services provided to you through Adult Day Care, Home Health Care, Hospice Services and Caregiver Training.

Home Health Aide means a person, other than an RN or nurse, who provides Maintenance or Personal Care Services through a Home Health Care Agency. A Home Health Aide must be licensed or certified under state law, if any, and acting within the scope of his or her license or certification at the time the treatment or service is performed.

Home Health Care means a program of medical and non-medical services provided to ill, disabled or infirm persons through a Home Health Care Agency or Independent Home Health Caregiver, including:

- professional nursing care by or under the supervision of an RN or other licensed nurse;
- care by a Home Health Aide;
- therapeutic care services by or under the supervision of a speech, occupational, physical or respiratory therapist licensed or certified under state law if any, or a registered dietician; or
- Homemaker Services.

Home Health Care is provided to you in a setting other than a Hospital, Nursing Facility or Assisted Living Facility.

Home Health Care Agency means a Hospital, agency, or other provider licensed or certified under state law, if any, to provide Home Health Care.

Homemaker Services means services which are designed to maintain independent living. Services shall consist of the following where applicable: Shopping, menu planning, meal preparation and light housekeeping.

Hospice Services means Qualified Long Term Care Services which provide a program of care to meet your needs in the event you become terminally ill.

Hospital means an institution or facility that is:

- licensed as a Hospital by the proper authority of the state in which it is located; or
- accredited as a Hospital by the Joint Commission on Accreditation of Hospitals.

Independent Home Health Caregiver means a person who is approved by us; and

- is independently employed and not associated with a Home Health Care Agency;

- provides care within the scope of his or her employment in the performance of Qualified Long Term Care Services; and
- is licensed or certified under state law, if any, and acting within the scope of his or her license at the time the treatment or service is performed.

Licensed Health Care Practitioner means:

- a Physician;
- a Registered Nurse; or
- a Licensed Social Worker.

The Licensed Health Care Practitioner must not be a member of your Family.

Licensed Social Worker means a duly licensed social worker acting within the scope of his or her license at the time the treatment or service is performed.

Maintenance or Personal Care Services means any care provided primarily to give needed assistance to you as a result of your being Chronically Ill (including protection of your health and safety due to a Severe Cognitive Impairment).

Medicare means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended.

Mental or Nervous Disorders means affective disorders, anxiety disorders, personality disorders, psychotic disorders, or other mental or emotional disease or disorders. However, this definition does not include Alzheimer's or other demonstrable organic diseases such as senile dementia.

Nursing Facility means a facility or institution, other than a Hospital, that:

- is licensed or certified by the state in which it is located;
- is a separate facility or a distinct part of another health care facility;
- provides 24-hour per day skilled, intermediate or custodial nursing care under the supervision of an RN or Physician; and
- maintains a daily record on each patient.

Nursing Facility does not include:

- a convalescent home, board and rest home, home for the aged, residential care facility, domiciliary and retirement care facility or training center; or
- government or veteran's facility or any other facility where the patient is not required to pay.

Physician, as defined in section 1861(r)(1) of the Social Security Act, is a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the state in which he or she performs such function or action, including osteopathic practitioners within the scope of his or her practice as defined by state law.

Plan of Care means a written plan prescribed by a Licensed Health Care Practitioner developed in consultation with you, based upon an assessment indicating you are Chronically Ill. The Plan of Care will recommend the necessary services to be performed. In addition, it will specifically identify the frequency and type of services most suitable to meet your needs, as well as the most appropriate providers for such services. The Plan of Care is updated as your needs change.

Policy means this contract with Berkshire Life Insurance Company of America.

Policy Schedule means the pages of this Policy that show Policy Information and Benefit Information.

Qualified Long Term Care Services means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating and rehabilitative services, and Maintenance or Personal Care Services, which are required by you when you are Chronically Ill, and are provided pursuant to a Plan of Care.

Registered Nurse (RN) means a duly licensed registered graduate professional nurse acting within the scope of his or her license at the time the treatment or service is performed.

Respite Care Services means Qualified Long Term Care Services provided on a short term basis to relieve family or friends who are the primary caregivers in your residence. Respite Care Services may be provided in your home, a Nursing Facility, Assisted Living Facility or through a community based program.

Severe Cognitive Impairment means your deterioration or loss of intellectual capacity, which requires Substantial Supervision by another person to protect yourself or others from threats to health and safety. It is measured by clinical evidence and standardized tests that reliably measure your impairment in:

- short or long term memory;
- your orientation as to person (such as who you are), place (such as your location) and time (such as day, date and year); and
- deductive or abstract reasoning.

A Severe Cognitive Impairment includes Alzheimer's disease and similar forms of irreversible dementia.

Single Claim Period means a claim for benefits under this Policy that is not interrupted by a period of 180 consecutive days. If you do not satisfy the conditions on Eligibility for Payment of Benefits (because you have recovered and you are no longer receiving benefits under this Policy) for 180 consecutive days or longer, a new Single Claim Period will be established.

Stand-By Assistance means the presence of another person within arm's reach of you that is necessary to prevent, by physical intervention, injury to you while you are performing the Activity of Daily Living.

Substantial Assistance means Hands-On or Stand-By Assistance.

Substantial Supervision means continual supervision by another person to protect you or others from threats to health or safety (such as may result from wandering) when you have a Severe Cognitive Impairment. Such supervision may include cueing by verbal prompting, gestures or other similar demonstrations.

We, Us, Our means Berkshire Life Insurance Company of America.

You, Your means the person (or persons under joint coverage) named as the insured(s) on the Policy Schedule.

LIMITATIONS OR CONDITIONS ON ELIGIBILITY FOR PAYMENT OF BENEFITS

Eligibility for Payment of Benefits

While this Policy is in force, you will be eligible for Payment of Benefits if you are Chronically Ill. This means that within the previous 12 months, you have been certified by a Licensed Health Care Practitioner as:

- being unable to perform, without Substantial Assistance, at least two Activities of Daily Living for an expected period of at least 90 days due to loss of functional capacity; or
- having a Severe Cognitive Impairment.

The expected 90-day period for loss of functional capacity does not establish an additional waiting period beyond any Elimination Period selected before benefits become payable.

Payment of Benefits

While this Policy is in force, we will pay benefits if:

- you satisfy Eligibility for Payment of Benefits;
- you have satisfied any applicable Elimination Period shown on the Policy Schedule;
- you receive services covered under this Policy pursuant to a Plan of Care;
- you are not receiving any other benefits covered under this Policy;
- you have not been paid benefits that exceed the Benefit Amount shown on the Policy Schedule;
- you satisfy the requirements under the FILING A CLAIM section; and
- your claim is not subject to any Limitations and Exclusions contained in this Policy.

Limitations and Exclusions

No benefits will be paid and the Elimination Period will not be satisfied for any confinement, care, treatment, or service(s):

- provided to you by a person in your Family;
- provided outside the United States or its territories, or Canada, except as described under Coverage Outside the United States in the Policy Benefits section of this Policy;
- for which you have no financial liability or that is provided at no charge in the absence of insurance;
- provided in facilities operated primarily for the treatment of alcoholism or drug addiction; or
- provided in facilities operated primarily for the treatment of Mental or Nervous Disorders.

Non-Duplication of Benefits

Benefits are not payable under this Policy for: (a) expenses incurred to the extent that such expenses are reimbursable under Medicare or would be so reimbursable but for the application of a deductible or coinsurance amount; or (b) for any other state or federal worker's compensation plan or other governmental program (except Medicaid).

For purposes of satisfying the Elimination Period, days on which you satisfy the conditions on Eligibility for Payment of Benefits, but coverage is excluded due to Non-Duplication of Benefits, will count toward satisfaction of the Elimination Period.

POLICY BENEFITS

Benefit Amount

Your Benefit Amount is shown on the Policy Schedule. The total of all benefits we will pay under this Policy and any attached riders will not exceed the Benefit Amount. Your coverage will end after we pay the total Benefit Amount.

Coverage Outside the United States

After you satisfy the conditions for Payment of Benefits, we will pay a Daily Benefit for covered services outside the United States or its territories, or Canada for up to 30 days per calendar year.

Payment will be the actual daily charges you incur for covered services, up to the Daily Benefit shown on the Policy Schedule. We will subtract the benefits we pay from the Benefit Amount.

Facility Care Services

After you satisfy the conditions for Payment of Benefits, we will pay a Daily Benefit for each day of Facility Care Services that you receive in a Nursing Facility or Assisted Living Facility.

Payment will be the actual daily Facility Care Services charges you incur, up to the Daily Benefit shown on the Policy Schedule. We will subtract the benefits we pay from the Benefit Amount.

Facility Bed Reservation

After you satisfy the conditions for Payment of Benefits, we will pay you a benefit for your Facility Bed Reservation if you:

- are receiving Facility Care Services;
- incur a temporary absence from a Nursing Facility or Assisted Living Facility; and
- are charged by the facility to reserve your accommodations.

Payment will be the actual daily charges you incur for the reservation, up to the Daily Benefit shown on the Policy Schedule for Facility Care Services. We will subtract the benefits we pay from the Benefit Amount. This benefit is payable for a maximum of 30 days per calendar year.

Home and Community Care Services

Home and Community Care Services are covered and will be payable if shown on the Policy Schedule. After you satisfy the conditions for Payment of Benefits, we will pay a benefit for each day of covered Home and Community Care Services (Adult Day Care, Home Health Care, Hospice Services) you receive.

Payment will be the actual daily Home and Community Care Services charges you incur, up to the Daily Benefit shown on the Policy Schedule. We will subtract the benefits we pay from the Benefit Amount. This benefit is not payable if you are receiving Facility Care Services or you are confined in a Hospital.

Emergency Response System

If you are receiving benefits under this Policy for Home and Community Care Services, we will reimburse you for charges incurred for an Emergency Response System up to $50 per month. This includes a device or system installed in your residence that provides you with a means of communication to request assistance in the event of a medical emergency. It is not intended as a security system for your residence.

We will subtract the benefits we pay from the Benefit Amount. This benefit is not payable if you are receiving Facility Care Services or you are confined in a Hospital.

Caregiver Training

If Home and Community Care Services are covered under this Policy, after you satisfy the conditions for Payment of Benefits, we will pay a benefit for Caregiver Training, if prescribed in your Plan of Care. This benefit is not subject to the Elimination Period. Use of this benefit does not count towards satisfaction of the Elimination Period for any other benefits payable under this Policy.

Payment will be the actual Caregiver Training charges you incur, up to the Maximum Lifetime Caregiver Training shown on the Policy Schedule. This is the maximum amount that we will reimburse for all Caregiver Training charges while you are insured under this Policy. Caregiver Training will only be provided to a person who will not be paid as your caregiver. We will subtract the benefits we pay from the Benefit Amount.

Respite Care Services

After you satisfy the conditions for Payment of Benefits, we will pay a benefit for each day of Respite Care Services that you receive. This benefit is not subject to the Elimination Period. Use of these services does not count towards satisfaction of the Elimination Period for any other benefits payable under this Policy.

Payment will be the actual daily Facility Care Services charges or the actual daily Home and Community Care Services charges (if covered under this Policy) you incur, up to the Daily Benefit shown on the Policy Schedule. We will subtract the benefits we pay from the Benefit Amount. Respite Care Services are payable for a maximum of 30 days per calendar year.

Alternative Plan of Care

If you are Chronically Ill and satisfy the conditions for Payment of Benefits, we will consider paying benefits for an Alternative Plan of Care for Qualified Long Term Care Services not specifically shown as being available under this Policy. Such benefits may include equipment purchases or rentals, permanent or temporary modifications to your residence (such as ramps or rails), or care services not normally covered under Home and Community Care Services. An Alternative Plan of Care is not available for providing Home and Community Care Services if this Policy provides Facility Care Services only. We reserve the right to make the final decision on any request for an Alternative Plan of Care.

We will reimburse you for charges incurred for an Alternative Plan of Care, up to the Maximum Lifetime Alternative Plan of Care shown on the Policy Schedule. The Alternative Plan of Care benefit amount agreed upon, divided by the Daily Benefit shown on the Policy Schedule, equals the number of subsequent days for which we will not pay additional benefits for Home and Community Care Services or Facility Care Services. This number of subsequent days will be considered to have been paid by the Alternative Plan of Care benefit amount agreed to. We will subtract the benefits we pay under an Alternative Plan of Care from the Benefit Amount.

We will pay for an Alternative Plan of Care if:

- you have satisfied the conditions for Payment of Benefits;

- you, your Licensed Health Care Practitioner and we agree that an Alternative Plan of Care is: (a) medically acceptable; and (b) the most cost effective manner in which to provide benefits for your claim under this Policy; and
- you agree that you will not receive payments for any other benefits under this Policy while Alternative Plan of Care benefits are being paid.

Optional Personal Care Advisor

Your Optional Personal Care Advisor will, if requested by you, assist with questions regarding such matters as:

- Eligibility for Payment of Benefits;
- appropriate level of care;
- availability of facilities and other care and service resources in your area; or
- any other questions you may have about a claim for benefits.

You may contact your Optional Personal Care Advisor by calling the toll-free number shown on the Policy Schedule.

You are not required to use these services in order to file a claim and there is no cost to you if you choose to use these services. No benefits will be deducted from the Benefit Amount for their use.

Optional Care Coordination

At your request, if you need Care Coordination assistance you may call the toll-free number shown on the Policy Schedule and we will arrange for a care coordinator to contact you. The care coordinator will be an RN who will:

- assess and coordinate appropriate care and services;
- provide assistance in developing a Plan of Care;
- if you wish, maintain a continuing role in arranging and monitoring services being provided; and
- assist with necessary claims documentation.

You are not required to use these services in order to file a claim and there is no cost to you if you choose to use these services. No benefits will be deducted from the Benefit Amount for their use.

FILING A CLAIM

To file a claim for benefits, please provide us with advance notice or advise us as quickly as possible by calling the toll-free number shown on the Policy Schedule.

Notice of Claim

You must give us written Notice of Claim within 30 days after you begin receiving care or services covered under this Policy, or as soon thereafter as reasonably possible. You may give notice or you may have someone do it for you. The notice must provide us with sufficient information to identify you. It should be mailed to us at our Long Term Care Administrative Office or to one of our agents.

Claim Forms

After you notify us of a claim, we will send you or your representative a claim form used for filing Proof of Loss. You or your representative must complete it and return it to us.

If we do not send you a claim form within 15 days of your notice to us, you may meet the Proof of Loss requirement by giving us a written statement within the time limit stated in the Proof of Loss section. The written statement must give us information sufficient to identify you and must outline the nature and extent of your loss.

Proof of Loss

You will be considered to have provided Proof of Loss when we receive a completed claim form and any necessary statements or bills which include the date, nature and charges for all covered care you have received. Proof of Loss must

be sent to us within 90 days after the date of your loss. If it is not possible to give us timely Proof of Loss, we will not reduce or deny your claim if Proof of Loss is filed as soon as you reasonably can provide the information to us.

If we do not pay benefits upon receipt of written Proof of Loss, we will mail you within 30 working days, a letter which states our reasons for not paying the claim, either in whole or in part. The letter will also provide you with a written itemization of any documents or other information needed to process the claim or any portions not paid.

In no event, except in the event of legal incapacity, may Proof of Loss be submitted later than one year from 90 days after the date of your loss.

Time of Payment of Claims

Benefits payable under this Policy will be paid promptly after we receive proper written Proof of Loss.

Payment of Claims

We will pay all benefits to you, or to the owner of this Policy if other than you, or to your assignee. Upon our receipt of proper written documentation, unassigned benefits remaining due upon your death may be paid to your estate. If benefits are payable to your estate, we may pay up to $1,000 to any relative of yours by blood or marriage who we find is entitled to it. Any payments made in good faith will discharge us with regard to such payment.

We may pay all or a portion of any benefits for care or services covered under this Policy to the provider of such care or services unless you instruct us in writing to do otherwise when you file your Proof of Loss with us. We do not require that you receive care or services from a specifically designated provider.

Extension of Benefits

Termination of this Policy will not terminate any benefits payable for Facility Care Services if your confinement begins while this Policy is in force and continues without interruption after this Policy terminates. Any benefits payable under this provision are subject to the Benefit Amount, any applicable Elimination Period and all other provisions and Limitations and Exclusions of this Policy.

Plan of Care Updates and Examinations

While you are receiving benefits under this Policy we will periodically require copies of updates to your Plan of Care, as well as an updated Licensed Health Care Practitioner certification as described under the conditions on Eligibility for Payment of Benefits in this Policy.

In addition, we may require that a Licensed Health Care Practitioner examine you or provide us with an assessment while a claim is pending or while you are receiving benefits, as often as reasonably required. We will pay for these examinations or assessments and will choose the individual to perform them.

Appealing a Claim

We will evaluate your claim based on the provisions of this Policy and the information given by you, your Licensed Health Care Practitioner and other available sources. We will inform you in writing if we deny your claim or any part of your claim. If you do not agree with a claim decision, you or your representative may appeal the denial. The appeal must be in writing to us and include all information that pertains to the claim. No special form is needed. We will review your request and notify you or your representative of our decision within 30 working days of receiving the request.

Right of Recovery

If we make any errors in processing your claim, we have the right to recover any overpayment of benefits. We will recover by offset any amounts that have not been previously recovered at the time we make another benefit payment.

Legal Action

Legal action to obtain benefits under this Policy may not be started earlier than 60 days after required Proof of Loss has been filed with us. Further, no legal action may be started later than 3 years after required Proof of Loss was filed with us.

PAYING YOUR PREMIUM

Premium Due Dates

The first premium is due on the Effective Date shown on the Policy Schedule. After the first premium has been paid, premiums will be due in the amount and frequency shown on the premium statement that we will mail to you.

Modes of Premium Payment

Premiums may be paid on an annual, semi-annual or quarterly basis, or by monthly automatic premium plan. We will change the mode of premium payment if we receive a proper written request at our Long Term Care Administrative Office before the Premium Due Date. The amount of each modal premium is calculated by multiplying the annual Policy premium by the applicable modal factors. The modal premiums for your Policy are shown on the Policy Schedule.

Premium Payment Mode	Modal Factor
Semi-Annually	0.52
Quarterly	0.27
Monthly	0.088

Payment Responsibility

You are responsible for payment of all your premiums due while coverage is in force. Payment must be sent to us at our Long Term Care Administrative Office or any other office that we may designate.

Unpaid Premium

We may deduct any premium due and unpaid from any claim payment payable under this Policy.

Waiver of Premium

After you (either insured under joint coverage) have been confined in a Nursing Facility or Assisted Living Facility for 90 days and you satisfy the conditions on Eligibility for Payment of Benefits, no premiums will be due following the 90th day. The 90 days need not be consecutive, but must be satisfied during a Single Claim Period.

We will return any unearned premium to you on a pro-rata basis. Premium paid during the 90-day period described above is considered unearned and will also be returned to you. The premium will be waived until you no longer satisfy the conditions on Eligibility for Payment of Benefits (because you have recovered and you are no longer confined in a Nursing Facility or Assisted Living Facility). Premium payments will then again become due. Any new Single Claim Period will require satisfaction of a new 90-day waiting period for Waiver of Premium, as described above.

Grace Period

Except for the first premium, you will have 31 days after each due date to pay the premium due. This Policy remains in force during the Grace Period.

Unintentional Lapse

If your premium is not paid by the 30th day of the Grace Period, we will provide written notice to you and any individuals designated by you to receive notice of non-payment of premium. Notice will be sent at least 30 days before cancellation of your coverage.

If your premium is not paid within 35 days after notice is sent, this Policy will lapse for non-payment of premium.

Refund of Unearned Premium

Upon your death, we will refund any unearned premium for this Policy on a pro-rata basis. We will make this refund in accordance with the Payment of Claims provision, within 30 days of receipt of proof of your death.

If you (both insureds under joint coverage) request in writing to cancel this Policy, we will refund any unearned premium to you on a pro-rata basis. Cancellation will be effective upon receipt of your request or a later date specified by you. Cancellation will be without prejudice to any claim originating prior to the effective date of cancellation.

GENERAL PROVISIONS

Misstatement of Age

If your age is misstated on the application, we may, at any time, adjust your benefits and/or premiums to reflect your correct age. If no coverage would have been provided based on your correct age, our liability is limited to a refund of any premium paid for this Policy and this Policy is null and void as of the Effective Date.

Entire Contract; Changes

This Policy, the attached application, plus any riders and additional attachments, is the entire contract. No agent, employee or person other than our President, Vice President or Secretary has authority to change this Policy or waive any of its provisions. No change in this Policy will be valid unless it has been endorsed on or attached to this Policy in writing by the President, Vice President or Secretary of Berkshire Life Insurance Company of America.

Incontestability

If this Policy has been in force for less than 6 months, upon a showing of misrepresentation that is material to the acceptance of coverage, we may rescind this Policy or deny an otherwise valid claim on this Policy.

If this Policy has been in force for at least 6 months, but less than 2 years, and if we can show the misrepresentation is both material to the acceptance of coverage and that it pertains to the condition for which benefits are sought, we may rescind this Policy or deny an otherwise valid claim on this Policy.

After this Policy has been in force for 2 years it is not contestable upon the grounds of misrepresentation alone. After 2 years, this Policy may be contested only upon a showing that you knowingly and intentionally misrepresented relevant facts relating to your health.

Policy Termination

This Policy will terminate and your coverage will end on the earliest of:

- the date that the total of all benefits paid under this Policy is equal to the Benefit Amount shown on the Policy Schedule;
- the date we receive a written request from you (both insureds under joint coverage) to cancel this Policy (or a later date specified by you in the cancellation request);
- the date this Policy lapses for non-payment of premium as described under the Unintentional Lapse provision; or
- the date of your death (last of your deaths under joint coverage).

If this Policy provides joint coverage and only one of you has exhausted the Benefit Amount as described above, coverage will continue for the remaining insured as described under the Joint Coverage provision below.

Reinstatement – Lapse Due to Severe Cognitive Impairment or Functional Incapacity

If your coverage has lapsed due to your Severe Cognitive Impairment or functional incapacity, your coverage may be reinstated without an application if:

- you or your representative requests reinstatement in writing within 6 months after your last premium was due;
- we receive evidence satisfactory to us that you have a Severe Cognitive Impairment or functional incapacity; and
- we receive all past due and unpaid premiums.

This Policy will then be reinstated as of the date of lapse and both you and we shall have the same rights that existed prior to the due date of the premium in default. Premium rates for this reinstated Policy will be based on your original issue age.

Reinstatement – Lapse Due to Nonpayment of Premium

Without requiring an application, we may accept your past due and unpaid premiums, up to 1 year after lapse. Those payments will reinstate this Policy and put it back in force.

If we require an application for reinstatement, your coverage may be reinstated within 1 year after lapse if:

- you complete the application for reinstatement;

- we receive all past due and unpaid premiums (for which we will give you a conditional receipt); and
- you are insurable under our underwriting rules in effect at the time you apply for reinstatement.

Reinstatement by application will be effective:

- on the date we approve your application; or
- on the 45th day following the date of the conditional receipt, if we have not previously declined your application in writing.

This reinstated Policy will cover only loss due to:

- sickness incurred more than 10 days after the date of reinstatement; and
- injury sustained after the date of reinstatement.

Upon reinstatement of this Policy both you and we shall have the same rights that existed prior to the due date of the premium in default. Premium rates for this reinstated Policy will be based on your original issue age.

Joint Coverage

This Policy provides equal coverage for two persons if both apply and are issued coverage under this Policy. The name of each insured covered under this Policy is shown on the Policy Schedule.

All benefits, Eligibility for Payment of Benefits and Payment of Benefits, Elimination Periods, Benefit Amount and Limitations and Exclusions described in this Policy or shown on the Policy Schedule apply to each insured individually and separately, unless otherwise noted.

When one of you dies (and we receive proof of death), or one of you exhausts your benefits or terminates coverage as described under the Policy Termination provision, coverage continues for the remaining insured. The new premium rate will be the premium that would have been charged for an individual Policy at the original issue age and risk class of the remaining insured. The premium will be based on the premium rate table in effect at the time of the death, exhaustion of benefits or termination. Any unearned portion of the difference between the original joint premium and the new premium will be refunded to the remaining insured on a pro-rata basis. The new premium for the continued coverage will be due on this Policy's next Premium Due Date.

If each of you provides a written request for termination of joint coverage, we will convert this joint Policy to separate individual policies with the same coverage, effective on the next Premium Due Date, terminating this joint coverage on that date. Your converted coverage will be at the same premium rate that would have been charged for an individual Policy at your original issue age and risk class. The premium will be based on the premium rate table in effect on the date the conversion is effective. Each of you will have 30 days to examine the converted Policy. It may be returned to us or any authorized agent or agency within 30 days after it is received. We will then refund any premium paid for the converted coverage and the Policy will be considered void from the date of conversion. Once joint coverage is terminated, the individual policies may not be converted back to joint coverage. Any applicable nonforfeiture benefits will be divided proportionately between the individual policies based on the individual premiums shown on the Policy Schedule.

Policy Ownership

You (both insureds under joint coverage) are the owner of this Policy unless otherwise provided in the application or changed by written request. While you are living, the owner may exercise every right and receive every benefit provided by this Policy. If the owner is not you and the owner dies while you are living, unless otherwise provided, all rights of the owner shall be transferred to the owner's executors or administrators.

Assignment

No assignment of interest under this Policy will be binding upon us unless the original or a copy of the assignment is filed with us at our Long Term Care Administrative Office. We do not assume any responsibility for the validity of an assignment.

Conformity with State Statutes

Any part of this Policy that, on the Effective Date, conflicts with the laws of the state in which you reside on such date, is hereby amended to meet the minimum requirements of those laws.

Berkshire Life Insurance Company of America
Home Office: Pittsfield, Massachusetts
Long Term Care Administrative Office
Post Office Box 4243
Woodland Hills, CA 91365-4243
888-505-8743

INDEMNITY BENEFIT RIDER

READ THIS RIDER CAREFULLY. It is a part of a legal contract between you and us.

This rider is part of the Policy. The Effective Date for this rider is shown on the Policy Schedule of the attached Policy. It is issued in consideration of your application and premium paid by you for this rider. All definitions, provisions, Limitations and Exclusions of the Policy apply to this rider unless changed by this rider.

Indemnity Benefit

If you satisfy the conditions for Payment of Benefits under the Policy, benefits payable to you for Qualified Long Term Care Services will be equal to the full Daily Benefit shown on the Policy Schedule, regardless of actual charges incurred by you. This applies to each benefit you qualify for as described under the Policy Benefits section in the Policy.

The Non-Duplication of Benefits provision stated in the Policy is DELETED in its entirety.

Free Look Period For 30 Days

If you are not satisfied with this rider, you may return it to us or any authorized agent or agency within 30 days from the date you receive it. We will then refund any premium you have paid for this rider and this rider will be considered never to have been in effect.

Executed for the Company at its Home Office in Pittsfield, Massachusetts.

John P. Cifu
Secretary

Joan Bancroft
President

Berkshire Life Insurance Company of America
Home Office: Pittsfield, Massachusetts
Long Term Care Administrative Office
Post Office Box 4243
Woodland Hills, CA 91365-4243
888-505-8743

WAIVER OF PREMIUM RIDER

READ THIS RIDER CAREFULLY. It is a part of a legal contract between you and us.

This rider is part of the Policy. The Effective Date for this rider is shown on the Policy Schedule of the attached Policy. It is issued in consideration of your application and premium paid by you for this rider. All definitions, provisions, Limitations and Exclusions of the Policy apply to this rider unless changed by this rider.

Waiver of Premium

After you (either insured under joint coverage) have received Home and Community Care Services for 90 days (regardless of the number of visits in a day) and you satisfy the conditions on Eligibility for Payment of Benefits, no premiums will be due following the 90th day. The 90 days need not be consecutive, but must be satisfied during a Single Claim Period. We will return any unearned premium to you on a pro-rata basis. Premium paid during the 90-day period described above is considered unearned premium and will also be returned to you.

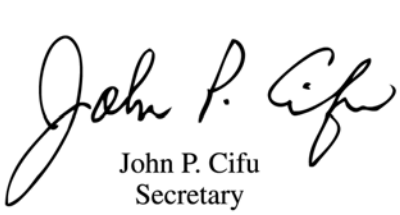
The premium will be waived until you no longer satisfy the conditions on Eligibility for Payment of Benefits (because you have recovered and you are no longer receiving Home and Community Care Services, or you are no longer confined in a Nursing Facility or Assisted Living Facility). Premium payments will then again be due. Any new Single Claim Period will require satisfaction of a new 90-day waiting period for Waiver of Premium as described above.

The waiting period for Waiver of Premium under the Policy for confinement in a Nursing Facility or Assisted Living Facility is 90 days. If you receive fewer than 90 days of Home and Community Care Services and do not qualify for Waiver of Premium under this rider, we will credit any day on which you receive Home and Community Care Services during a Single Claim Period toward satisfaction of the 90-day waiting period for Waiver of Premium under the Policy.

Free Look Period For 30 Days

If you are not satisfied with this rider, you may return it to us or any authorized agent or agency within 30 days from the date you receive it. We will then refund any premium you have paid for this rider and this rider will be considered never to have been in effect.

Executed for the Company at its Home Office in Pittsfield, Massachusetts.



John P. Cifu
Secretary

Joan Bancroft
President

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Home Office: Pittsfield, Massachusetts
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RESTORATION OF BENEFITS RIDER

READ THIS RIDER CAREFULLY. It is a part of a legal contract between you and us.

This rider is part of the Policy. The Effective Date for this rider is shown on the Policy Schedule of the attached Policy. It is issued in consideration of your application and premium paid by you for this rider. All definitions, provisions, Limitations and Exclusions of the Policy apply to this rider unless changed by this rider.

Restoration of the Benefit Amount

Benefits we pay during a Single Claim Period will not exceed the Benefit Amount shown on the Policy Schedule and coverage will terminate as described in the Policy under the Policy Termination provision. However, we will restore the Benefit Amount if for a period of 180 consecutive days:

- the Policy is in force;
- you do not satisfy the conditions on Eligibility for Payment of Benefits (because you have recovered); and
- you have not received benefits under the Policy.

Subject to the additional terms as described in the Policy under the Policy Termination provision, your coverage will end on the date the total of all Benefits paid under the Policy is equal to the Maximum Benefit Amount with Restoration of Benefits.

If the Policy provides joint coverage and only one of you has exhausted the Maximum Benefit Amount with Restoration of Benefits, coverage will continue for the remaining insured as described under the Joint Coverage provision in the Policy.

Benefits will be restored up to twice the original Benefit Amount shown on the Policy Schedule.

Free Look Period For 30 Days

If you are not satisfied with this rider, you may return it to us or any authorized agent or agency within 30 days from the date you receive it. We will then refund any premium you have paid for this rider and this rider will be considered never to have been in effect.

Executed for the Company at its Home Office in Pittsfield, Massachusetts.

John P. Cifu
Secretary

Joan Bancroft
President

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10-YEAR PREMIUM PAYMENT ENDORSEMENT

This endorsement is attached to and made part of the Policy as of the Effective Date. It is issued in consideration of your application and premium submitted by you for this endorsement.

10-Year Premium Payment Option

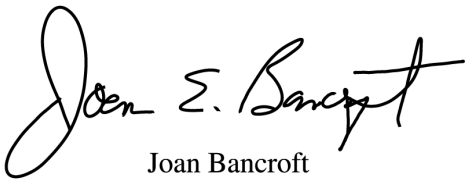
This endorsement provides that the Policy premiums will be payable over a 10-year period, after which no further premiums will be due.

The following language is added to the **GUARANTEED RENEWABLE** provision shown on the first page of the Policy:

To renew during the 10-Year Premium Payment Period shown on the Policy Schedule, you must pay the premium due by the Premium Due Date or within the Grace Period. At the end of the 10th Policy year, if each required premium has been paid, the Policy will automatically be renewed for the rest of your life with no further premium due. Premiums are only subject to change during the 10-Year Premium Payment Period.

Executed for the Company at its Home Office in Pittsfield, Massachusetts.

John P. Cifu
Secretary



Joan Bancroft
President

Berkshire Life Insurance Company of America
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PAID-UP AT AGE 65 PREMIUM PAYMENT ENDORSEMENT

This endorsement is attached to and made part of the Policy as of the Effective Date. It is issued in consideration of your application and premium submitted by you for this endorsement.

Paid-Up At Age 65 Premium Payment Option

This endorsement provides that the Policy premiums will be payable until you reach age 65 (first to reach age 65 under joint coverage), after which no further premiums will be due.

The following language is added to the **GUARANTEED RENEWABLE** provision shown on the first page of the Policy:

To renew during the Premium Payment Period shown on the Policy Schedule, you must pay the premium due by the Premium Due Date or within the Grace Period. On your first Policy Anniversary Date after reaching age 65 (first to reach age 65 under joint coverage), if each required premium has been paid, the Policy will automatically be renewed for the rest of your life with no further premium due. Premiums are only subject to change during the Premium Payment Period.

Executed for the Company at its Home Office in Pittsfield, Massachusetts.

John P. Cifu
Secretary

Joan Bancroft
President

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SHORTENED BENEFIT PERIOD NONFORFEITURE RIDER

READ THIS RIDER CAREFULLY. It is a part of a legal contract between you and us.

This rider is part of the Policy. The Effective Date for this rider is shown on the Policy Schedule of the attached Policy. It is issued in consideration of your application and premium paid by you for this rider. All definitions, provisions, Limitations and Exclusions of the Policy apply to this rider unless changed by this rider.

Shortened Benefit Period

If the Policy has been in force for 3 or more years and the Policy lapses for nonpayment of premium as described under the Grace Period and Unintentional Lapse provisions of the Policy:

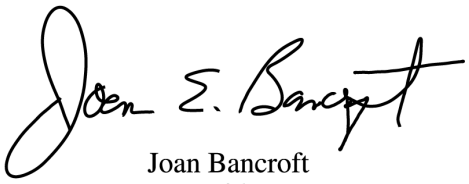
- Your coverage will continue and benefits will be payable based on the Daily Benefit shown on the Policy Schedule (and any previous increases due to an Inflation Protection Rider) in effect on the date of lapse. No further benefit increases will occur under any Inflation Protection Rider, if attached to the Policy.
- The new Benefit Amount becomes equal to the greater of: (a) the total of premiums paid for the Policy and all riders; or (b) 30 times the Daily Benefit in effect on the date of lapse. This new Benefit Amount replaces the Benefit Amount in effect on the date of lapse. Any benefits paid to you after the Policy lapses will be subtracted from this new Benefit Amount.
- Your coverage under this rider is subject to the same Policy benefit provisions, Elimination Period, Limitations and Exclusions and all other provisions of the Policy and riders that were in effect prior to Policy lapse, except any Inflation Protection Rider, if attached to the Policy.

Free Look Period For 30 Days

If you are not satisfied with this rider, you may return it to us or any authorized agent or agency within 30 days from the date you receive it. We will then refund any premium you have paid for this rider and this rider will be considered never to have been in effect.

Executed for the Company at its Home Office in Pittsfield, Massachusetts.

John P. Cifu
Secretary



Joan Bancroft
President

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MONTHLY BENEFIT RIDER

READ THIS RIDER CAREFULLY. It is a part of a legal contract between you and us.

This rider is part of the Policy. The Effective Date for this rider is shown on the Policy Schedule of the attached Policy. It is issued in consideration of your application and premium paid by you for this rider. All definitions, provisions, Limitations and Exclusions of the Policy apply to this rider unless changed by this rider.

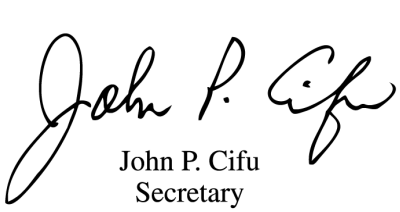
Monthly Benefit

This rider changes the Daily Benefit for Home and Community Care Services to a Monthly Benefit. If you otherwise satisfy the conditions for Payment of Benefits for Home and Community Care Services, we will pay the actual Home and Community Care Services charges you incur during any calendar month, up to 31 times the Daily Benefit shown on the Policy Schedule.

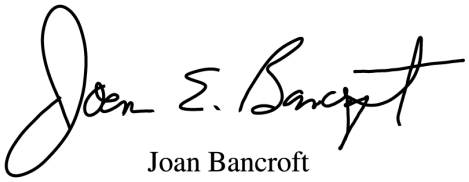
Free Look Period For 30 Days

If you are not satisfied with this rider, you may return it to us or any authorized agent or agency within 30 days from the date you receive it. We will then refund any premium you have paid for this rider and this rider will be considered never to have been in effect.

Executed for the Company at its Home Office in Pittsfield, Massachusetts.



John P. Cifu
Secretary



Joan Bancroft
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PAID-UP SURVIVOR BENEFIT RIDER

READ THIS RIDER CAREFULLY. It is a part of a legal contract between you and us.

This rider is part of the Policy. The Effective Date for this rider is shown on the Policy Schedule of the attached Policy. It is issued in consideration of your application and premium paid by you for this rider. All definitions, provisions, Limitations and Exclusions of the Policy apply to this rider unless changed by this rider.

Paid-Up Survivor Benefit

The Policy to which this rider is attached will be paid-up and no further premium payments will be required for the Policy or any attached riders after both of the following have occurred:

- The end of the 10th Policy year; and
- The date of death of either insured.

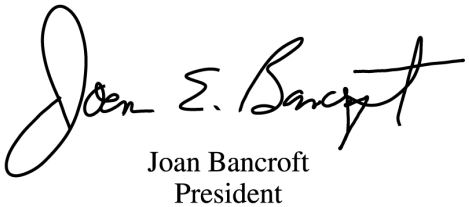
In the event one insured dies prior to the end of the 10th Policy year, the premium rate payable by the surviving insured for the balance of the 10-year period will be the rate that would have been charged for an individual Policy at the original issue age and risk class of the surviving insured. However, the new premium will be based on the premium rate table in effect at the time of death of the deceased insured. This new premium will be due on the Policy's next Premium Due Date. It will be payable until the end of the 10th Policy year at which time the Policy will be paid-up and no further premium payments will be due. Any unearned portion of the difference between the old premium and the new premium will be refunded on a pro-rata basis.

Free Look Period For 30 Days

If you are not satisfied with this rider, you may return it to us or any authorized agent or agency within 30 days from the date you receive it. We will then refund any premium you have paid for this rider and this rider will be considered never to have been in effect.

Executed for the Company at its Home Office in Pittsfield, Massachusetts.

John P. Cifu
Secretary



Joan Bancroft
President

Agent's Certification

THIS AGENT'S CERTIFICATION IS TO BE USED WITH THE APPLICATION ON:

Print Applicant's Name _____ Print Joint Applicant's Name _____

Yes No

1. How well do you know the Applicant(s)?

❍ Known well for ____ years ❍ Met very recently

❍ Known slightly for ____ years ❍ Relative? _____

❍ ❍ **2a. To the best of your knowledge, is the insurance applied for intended to replace any long term care, medical or health insurance in force with this or any other company?**

2b. List any other health insurance policies that you have sold to the applicant(s):

(a) Which of the policies listed above are still in force, if any?

(b) Which of the policies listed above sold in the past five (5) years are no longer in force, if any?

❍ ❍ **3. Did you ask the applicant(s) all the questions face to face and witness their signature(s)?**
If "No", provide details: _____

❍ ❍ **4. Did you deliver to the applicant(s) the Outline of Coverage, the required Disclosures, including the Notice of Insurance Information Practices, the NAIC Shopper's Guide and the Notice of Privacy Practices?**

Licensed Agent's Name	Agent's Code	Split Percentage	Manager/GA Code
		%	__ __-__ __
		%	__ __-__ __
		%	__ __-__ __

I represent that to the best of my knowledge and belief the information provided in the application is complete, accurate and correctly recorded; and there is nothing adversely affecting the insurability of the applicant(s) other than as indicated in the application. I have reviewed the current health insurance coverage of the applicant(s) and find that the coverage of the type and amount applied for is appropriate for the needs of the applicant(s). Further, if this is a replacement, I have reviewed the current health insurance coverage of the applicant(s) and find that this replacement is appropriate for the needs of the applicant(s). I represent that I am duly licensed in the state in which the application was signed.

Type or Print Agent's Name _____ ✘ _____ Signature of Soliciting Agent

Soliciting Agent's Code _____ Soliciting Agent's Social Security Number _____

Date _____

RETURN TO LONG TERM CARE ADMINISTRATIVE OFFICE

Berkshire Life Insurance Company of America
Home Office: Pittsfield, Massachusetts
Long Term Care Administrative Office
Post Office Box 4243
Woodland Hills, CA 91365-4243
888-505-8743

NOTICE OF INSURANCE INFORMATION PRACTICES AND CONDITIONS OF COVERAGE

DISCLOSURE STATEMENT

NOTICE OF INSURANCE INFORMATION PRACTICES — To evaluate your application, we will need some personal information about you. It may be necessary to obtain some of that information from sources other than yourself. For your protection, you have a qualified right to learn what information we obtain about you. You also have the right to request correction of any erroneous information. The information we obtain about you will be used by Berkshire Life Insurance Company of America to determine eligibility for insurance and/or benefits under an existing policy and for other business purposes in connection with the insurance relationship. A detailed description of our information practices is contained in the Notice of Privacy Practices furnished to you with your application.

CONDITIONS OF COVERAGE

I/We _____ the applicant(s) have applied for a long term care insurance policy from Berkshire Life Insurance Company of America (the Company) and have submitted $ _____ to the Company. The minimum amount of premium which may accompany an application is a monthly premium amount. It is understood and agreed that no liability is created or assumed by the Company, except for the refund of any premium amount submitted, unless and until a long term care insurance policy becomes effective. If approved, the effective date will be stated in the policy issued to the applicant(s).

The insurance applied for will become effective and in force only if:

1. This application is approved by the Company; and
2. A policy is issued during the lifetime of the applicant(s); and
3. The initial premium payment has been paid; and
4. Until the effective date of the policy as set by the Company, the health status of the applicant(s) remains insurable under the Company's underwriting standards.

Requests for a specific effective date are honored at the Company's discretion in accordance with its published guidelines on policy dating upon the conclusion of the underwriting review.

Should the applicant(s) be determined uninsurable based on the Company's underwriting standards, or if the Company is unable to obtain required underwriting information within 90 days, the amount submitted will be returned to the applicant(s). Should the amount submitted not be honored by the applicant's bank, the Company will discontinue consideration of the application.

No agent or broker has the authority to waive or alter any of the terms or conditions of the application for insurance or these Conditions of Coverage.

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO BERKSHIRE LIFE INSURANCE COMPANY OF AMERICA. DO NOT MAKE CHECK PAYABLE TO THE AGENT, AGENCY, OR LEAVE PAYEE BLANK.

I/We have read and understand the Conditions of Coverage.

Signed at _____ _____
City, State Date

_____ _____
Applicant's Signature Joint Applicant's Signature

_____ _____
Licensed Agent's Signature Date

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SUPPLEMENTAL APPLICATION FOR POLICY OWNERSHIP

(PLEASE PRINT)

BG01AO(06/04)

Applicant (First Name, Initial, Last Name)	Birthdate	Social Security Number
Joint Applicant (First Name, Initial, Last Name)	Birthdate	Social Security Number
Policy Owner and Relationship to Applicant(s)		Social Security or Tax I.D. Number
Residence Address (Street, City, State, Zip)		
Bill to: ❍ Owner ❍ Insured	Policy Owner's Billing Address - If Different (Name, Street, City, State, Zip)	
Policy Owner is: ❍ Individual ❍ Partnership ❍ Corporation ❍ Trustee		
Contingent Policy Owner and Relationship to Applicant(s)		Social Security or Tax I.D. Number
Residence Address (Street, City, State, Zip)		
Contingent Policy Owner's Billing Address - If Different (Name, Street, City, State, Zip)		
Contingent Policy Owner is: ❍ Individual ❍ Partnership ❍ Corporation ❍ Trustee		

Signed at _____
City, State

_____
Date

_____
Applicant's Signature

_____
Policy Owner's Signature

_____
Joint Applicant's Signature

_____
Agent's Signature

RETURN TO LONG TERM CARE ADMINISTRATIVE OFFICE

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888-505-8743

AUTHORIZATION FOR DISCLOSURE, RECEIPT AND USE OF PERSONAL HEALTH INFORMATION

This Authorization complies with the HIPAA Privacy Rule

"I", "me", "my" means each Applicant signing this Authorization.

AUTHORIZATION FOR DISCLOSURE

I authorize any licensed physician or licensed health care practitioner, hospital, clinic, medical facility, health care provider, insurance company or health plan that has provided treatment, payment or health care services to me or any other insurance company to which I have applied for insurance coverage ("My Providers"), to disclose my entire medical record and any knowledge of my past or present health or medical condition to Berkshire Life Insurance Company of America, its reinsurers and any third party administrator designated by Berkshire Life Insurance Company of America ("the Company"). This includes any information relating to HIV, AIDS and any sexually transmitted diseases, mental illness, the use of drugs, alcohol and tobacco, but excludes psychotherapy notes. Psychotherapy notes mean notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. Psychotherapy notes exclude the following information that is subject to disclosure under this Authorization: medication prescription and monitoring; counseling session start and stop times; the modalities and frequencies of treatment furnished; results of clinical tests; and any summary of the following items: diagnosis; functional status; the treatment plan; symptoms; prognosis; and progress to date.

By my signature below, I terminate any agreements I have made with My Providers to restrict information in my medical records or any knowledge of my past or present health or medical condition and I instruct My Providers to release and disclose my entire medical record and other records or knowledge of me or my health without restriction.

AUTHORIZATION FOR RECEIPT AND USE

I authorize the employees and business associates of the Company, its reinsurers and any third party administrator designated by the Company who are responsible for the processing of my application for long term care insurance to receive and use any information I have provided on my application form or provided by me during the course of a personal interview with me and to receive and use any information provided by other parties under the above Authorization For Disclosure for the purpose of determining my eligibility to obtain coverage under the long term care insurance policy for which I have applied, and to determine the rates and terms which apply to any policy issued.

I understand that the information which will be provided under this Authorization is necessary for the Company to determine my eligibility for coverage under the long term care insurance policy I have applied for and that the Company will condition the review of my application for long term care insurance on my providing this Authorization. I also understand that my application may be denied if I refuse to provide this Authorization.

REDISCLOSURE OF INFORMATION

I understand that if the person or entity that receives information provided pursuant to this Authorization is not subject to federal privacy regulations, the information may be redisclosed and will no longer be protected by the federal privacy regulations. In the case of this Authorization, however, the information described above will be received by an insurance company which is covered by the federal privacy regulations, and will not be used or redisclosed except as described above or required by law, and the information will continue to be protected under the federal privacy regulations.

REVOCATION OF AUTHORIZATION

I understand that I may revoke this Authorization in writing at any time by sending a written revocation to: *Berkshire Life Insurance Company of America, ATTN: Privacy Administrator, P.O. Box 4243, Woodland Hills, CA 91365-4243*. I also understand that any such revocation will not be effective to the extent that action has been taken by the Company in reliance on this Authorization or the extent that the Company has a legal right to contest a claim under the policy which I have applied for or to contest the policy itself.

EXPIRATION OF AUTHORIZATION

This Authorization will be valid for 24 months from the date of my signature below. A copy of this Authorization is as valid as the original.

Applicant's Name (Please Print)	**Date of Birth**
Applicant's Signature	**Date**
Joint Applicant's Name (Please Print)	**Date of Birth**
Joint Applicant's Signature	**Date**

Berkshire Life Insurance Company of America, Pittsfield, MA is a wholly owned stock subsidiary of The Guardian Life Insurance Company of America, New York, NY.

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AUTHORIZATION FOR DISCLOSURE, RECEIPT AND USE OF PERSONAL HEALTH INFORMATION

This Authorization complies with the HIPAA Privacy Rule

"I", "me", "my" means each Applicant signing this Authorization.

AUTHORIZATION FOR DISCLOSURE

I authorize any licensed physician or licensed health care practitioner, hospital, clinic, medical facility, health care provider, insurance company or health plan that has provided treatment, payment or health care services to me or any other insurance company to which I have applied for insurance coverage ("My Providers"), to disclose my entire medical record and any knowledge of my past or present health or medical condition to Berkshire Life Insurance Company of America, its reinsurers and any third party administrator designated by Berkshire Life Insurance Company of America ("the Company"). This includes any information relating to HIV, AIDS and any sexually transmitted diseases, mental illness, the use of drugs, alcohol and tobacco, but excludes psychotherapy notes. Psychotherapy notes mean notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. Psychotherapy notes exclude the following information that is subject to disclosure under this Authorization: medication prescription and monitoring; counseling session start and stop times; the modalities and frequencies of treatment furnished; results of clinical tests; and any summary of the following items: diagnosis; functional status; the treatment plan; symptoms; prognosis; and progress to date.

By my signature below, I terminate any agreements I have made with My Providers to restrict information in my medical records or any knowledge of my past or present health or medical condition and I instruct My Providers to release and disclose my entire medical record and other records or knowledge of me or my health without restriction.

AUTHORIZATION FOR RECEIPT AND USE

I authorize the employees and business associates of the Company, its reinsurers and any third party administrator designated by the Company who are responsible for the processing of my application for long term care insurance to receive and use any information I have provided on my application form or provided by me during the course of a personal interview with me and to receive and use any information provided by other parties under the above Authorization For Disclosure for the purpose of determining my eligibility to obtain coverage under the long term care insurance policy for which I have applied, and to determine the rates and terms which apply to any policy issued.

I understand that the information which will be provided under this Authorization is necessary for the Company to determine my eligibility for coverage under the long term care insurance policy I have applied for and that the Company will condition the review of my application for long term care insurance on my providing this Authorization. I also understand that my application may be denied if I refuse to provide this Authorization.

REDISCLOSURE OF INFORMATION

I understand that if the person or entity that receives information provided pursuant to this Authorization is not subject to federal privacy regulations, the information may be redisclosed and will no longer be protected by the federal privacy regulations. In the case of this Authorization, however, the information described above will be received by an insurance company which is covered by the federal privacy regulations, and will not be used or redisclosed except as described above or required by law, and the information will continue to be protected under the federal privacy regulations.

REVOCATION OF AUTHORIZATION

I understand that I may revoke this Authorization in writing at any time by sending a written revocation to: *Berkshire Life Insurance Company of America, ATTN: Privacy Administrator, P.O. Box 4243, Woodland Hills, CA 91365-4243*. I also understand that any such revocation will not be effective to the extent that action has been taken by the Company in reliance on this Authorization or the extent that the Company has a legal right to contest a claim under the policy which I have applied for or to contest the policy itself.

EXPIRATION OF AUTHORIZATION

This Authorization will be valid for 24 months from the date of my signature below. A copy of this Authorization is as valid as the original.

Applicant's Name (Please Print)	**Date of Birth**
Applicant's Signature	**Date**
Joint Applicant's Name (Please Print)	**Date of Birth**
Joint Applicant's Signature	**Date**

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IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

Federal law requires us to inform you that this insurance duplicates Medicare benefits in some situations.

- This is long term care insurance that provides benefits for covered nursing home and home care services.
- In some situations Medicare pays for short periods of skilled nursing home care, limited home health services and hospice care.
- This insurance does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Neither Medicare nor Medicare Supplement insurance provides benefits for most long term care expenses.

Before You Buy This Insurance

✓ Check the coverage in **all** health insurance policies you already have.

✓ For more information about long term care insurance, review the *Shopper's Guide to Long Term Care Insurance*, available from the insurance company.

✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

Berkshire Life Insurance Company of America
Home Office: Pittsfield, Massachusetts
Long Term Care Administrative Office
Post Office Box 4243
Woodland Hills, CA 91365-4243
888-505-8743

NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG TERM CARE INSURANCE

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE

According to your application, you intend to lapse or otherwise terminate existing accident and sickness or long term care insurance and replace it with an individual policy to be issued by Berkshire Life Insurance Company of America. Your new policy provides 30 days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy. You should review this new coverage carefully, comparing it with all accident and sickness or long term care insurance coverage you now have and terminate your present policy only if, after due consideration, you find that purchase of this long term care coverage is a wise decision.

STATEMENT TO APPLICANT BY AGENT (BROKER OR OTHER REPRESENTATIVE)

(Use additional sheets as necessary)

I have reviewed your current medical or health or long term care insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

1. If you are replacing existing long term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
2. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before your sign it, reread it carefully to be certain that all information has been properly recorded.

_____ _____
(Signature of agent, broker or other representative) *(Typed name of agent or broker)*

_____
(Typed address of agent or broker)

The above "Notice to Applicant" was delivered to me on:

_____ _____
(Date) *(Applicant's signature)*

_____ _____
(Date) *(Joint Applicant's signature)*

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NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG TERM CARE INSURANCE

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According to your application, you intend to lapse or otherwise terminate existing accident and sickness or long term care insurance and replace it with an individual policy to be issued by Berkshire Life Insurance Company of America. Your new policy provides 30 days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy. You should review this new coverage carefully, comparing it with all accident and sickness or long term care insurance coverage you now have and terminate your present policy only if, after due consideration, you find that purchase of this long term care coverage is a wise decision.

STATEMENT TO APPLICANT BY AGENT (BROKER OR OTHER REPRESENTATIVE)

(Use additional sheets as necessary)

I have reviewed your current medical or health or long term care insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

1. If you are replacing existing long term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
2. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before your sign it, reread it carefully to be certain that all information has been properly recorded.

_____ _____
(Signature of agent, broker or other representative) *(Typed name of agent or broker)*

_____
(Typed address of agent or broker)

The above "Notice to Applicant" was delivered to me on:

_____ _____
(Date) *(Applicant's signature)*

_____ _____
(Date) *(Joint Applicant's signature)*

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CONTINGENT BENEFIT UPON LAPSE ENDORSEMENT

This endorsement is attached to and made part of the Policy as of the Effective Date.

Contingent Benefit Upon Lapse

If we:

(a) increase the premium rates under your Policy which results in a cumulative increase of the annual premium equal to or exceeding the percentage of your initial annual premium, as set forth in the table below and;

(b) the Policy lapses as described in the Grace Period and Unintentional Lapse provisions of the Policy within 120 days of the due date for the payment of the increased premium; then

(c) the following options will become available under the Policy:

A. The Benefit Amount shown on the Policy Schedule page of the Policy may be reduced. This may be accomplished by either reduction of the Daily Benefit or Benefit Period, (subject to the availability of either one), to provide for a Benefit Amount that the current premium payable under the Policy will purchase. Reduction of the Benefit Amount will not be subject to evidence of insurability; or

B. The Policy may be converted to a paid-up status with the Shortened Benefit Period described below. This option may be elected at any time during the 120-day period referenced above. In addition, if the Policy lapses for nonpayment of premium during this 120-day period, this option will automatically be provided under the Policy.

Shortened Benefit Period

Your coverage will continue and benefits will be payable based on the Daily Benefit shown on the Policy Schedule (and any previous increases due to any Inflation Protection Rider) in effect on the date of lapse, but only until the total of benefits payable under the Policy and riders equals the total of premium paid. No further benefit increases will occur under any Inflation Protection Rider, if attached to the Policy.

The Benefit Amount becomes equal to the greater of: (a) the total of premiums paid for the Policy and all riders; but (b) in no event less than thirty (30) times the Daily Benefit in effect on the date of lapse. This Benefit Amount replaces the Benefit Amount in effect on the date of lapse. Any benefits paid to you after the Policy lapses will be subtracted from this new Benefit Amount.

Your coverage is subject to the same Policy benefit provisions, Elimination Period, Limitations and Exclusions, and all other provisions of the Policy and riders that were in effect prior to Policy lapse, except any Inflation Protection Rider, if attached to the Policy.

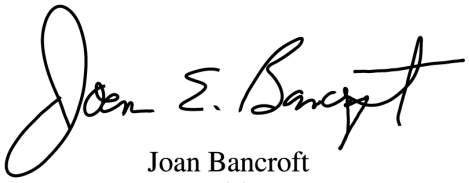
(over)

Triggers for a Substantial Premium Increase

Issue Age	Percentage Increase Over Initial Premium
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%

Executed for the Company at its Home Office in Pittsfield, Massachusetts.

John P. Cifu
Secretary



Joan Bancroft
President

Berkshire Life Insurance Company of America
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Woodland Hills, CA 91365-4243
888-505-8743

CONTINGENT BENEFIT UPON LAPSE ENDORSEMENT
(Limited Premium Payment Policy)

This endorsement is attached to and made part of the Policy as of the Effective Date.

Contingent Benefit Upon Lapse

If we:

(a) increase the premium rates under the Policy, which results in a cumulative increase of the annual premium equal to or exceeding the percentage of your initial annual premium, as set forth in the table below; and

(b) the Policy lapses as described in the Grace Period and Unintentional Lapse provision of the Policy within 120 days of the due date for the payment of the increased premium; and

(c) the ratio of the number of months you have already paid premium is 40% or more than the number of months you originally agreed to pay; then

(d) the following options will become available under the Policy:

A. The Benefit Amount shown on the Policy Schedule page of the Policy may be reduced. This may be accomplished by either reduction of the Daily Benefit or Benefit Period, (subject to the availability of either one), to provide for a Benefit Amount that the current premium payable under the Policy will purchase. Reduction of the Benefit Amount will not be subject to evidence of insurability; or

B. The Policy may be converted to a paid-up status and the total lifetime Benefit Amount for your reduced paid up Policy will be determined by multiplying 90% of the lifetime Benefit Amount, available at the time the Policy becomes paid-up, by the ratio of the number of months you have already paid premiums under the Policy, to the number of months you agreed to pay them at time of application.

The Daily Benefit Amount shown on the Policy Schedule page of your Policy will also be adjusted by the same ratio described above.

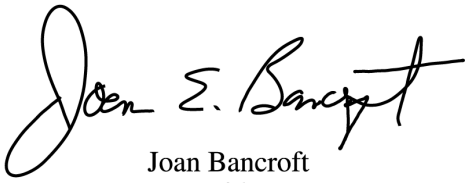
(over)

If you purchased a Policy with a lifetime Benefit Amount, only the Daily Benefit Amount shown on the Policy Schedule page of the Policy will be adjusted by the applicable ratio.

Triggers for a Substantial Premium Increase	
Issue Age	**Percent Increase Over Initial Premium**
Under 65	50%
65-80	30%
Over 80	10%

Executed for the Company at its Home Office in Pittsfield, Massachusetts.

John P. Cifu
Secretary



Joan Bancroft
President

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Long Term Care Insurance
Personal Worksheet

People buy long term care insurance for many reasons. Some don't want to use their own assets to pay for long term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid. But long term care insurance may be expensive and may not be right for everyone.

By state law, the insurance company must fill out part of the information on this worksheet and **ask** you to fill out the rest to help you and the company decide if you should buy this policy.

Premium Information

Policy Form Numbers: _____

The premium for the coverage you are considering will be $ _____ per _____ .

Type of Policy: Guaranteed Renewable

The Company's Right To Increase Premiums

The Company has a right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in this state.

Rate Increase History

The company has sold long term care insurance since 2004 and has sold this policy since 2004. The company has never raised its rates for any long term care policy it has sold in this state or any other state.

Questions Related To Your Income

How will you pay each year's premium?

❍ From my income ❍ From my Savings/Investments ❍ My family will pay

❍ Have you considered whether you could afford to keep this policy if the premiums went up, for example, by 20%?

What Is Your Annual Income? (check one)

❍ Under $10,000 ❍ $10-20,000 ❍ $20-30,000 ❍ $30-50,000 ❍ Over $50,000

How do you expect your income to change over the next 10 years? (check one)

❍ No change ❍ Increase ❍ Decrease

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

Turn the Page

Will You Buy Inflation Protection? (check one) ❍ Yes ❍ No

If not, have you considered how you will pay for the difference between future costs and your daily benefit amount?

❍ From my income ❍ From my Savings/Investments ❍ My family will pay

The national average annual cost of care in 2001[1] was: $56,000 in a nursing home; $22,476 in an assisted living facility and $14,000 for home health care, but these figures vary across the country. In ten years the national average annual cost would be about $91,280 in a nursing home; $36,636 in an assisted living facility and $22,820 for home health care, if costs increase 5% annually.

What Elimination Period Are You Considering? Number of Days _____ Approximate cost $ _____ for that period of care.

How are you planning to pay for your care during the elimination period? (check one)

❍ From my income ❍ From my Savings/Investments ❍ My family will pay

Questions Related To Your Savings and Investments

Not counting your home, about how much are all of your assets (savings and investments) worth? (check one)

❍ Under $20,000 ❍ $20,000-30,000 ❍ $30,000-50,000 ❍ Over $50,000

How do you expect your assets to change over the next ten years? (check one)

❍ Stay about the same ❍ Increase ❍ Decrease

If you are buying this policy to protect your assets and your assets are less than $30,000, you may wish to consider other options for financing your long term care.

Comparison To Current Coverage

If you have existing long term care coverage and you intend to add to or replace your current coverage, please indicate your reason for doing so (check one):

❍ Additional or different benefits (please specify): _____

❍ No change in benefits, but lower premiums

❍ Fewer benefits and lower premiums

❍ Other (please specify): _____

Premium for your current long term care coverage: $ _____ per _____ .

[1] 2003 NAIC Shopper's Guide

Continued on Next Page

Disclosure Statement

(Check One)

❍ The answers to the questions above describe my financial situation.

Or

❍ I choose not to complete this information. However, I still want the Company to consider my application (complete Authorization to Process Application below).

❍ I acknowledge that the agent (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increase in the future. I understand the above disclosures. **I understand that the rates for this policy may increase in the future.** *(This box must be checked in order to consider your application for Long Term Care.)*

Signed: _____ _____

(Applicant) (Date)

_____ _____

(Joint Applicant) (Date)

❍ I explained to the applicant the importance of completing this information.

Signed: _____ _____

(Agent) (Date)

_____

(Agent's Printed Name)

In order for us to process your application, please return this signed statement to Berkshire Life Insurance Company of America, along with your application.

My agent has advised me that this policy does not appear to be suitable for me. However, I still want the Company to consider my application.

Signed: _____ _____

(Applicant) (Date)

_____ _____

(Joint Applicant) (Date)

The Company may contact you to verify your answers.

This confidential information will be used only to determine your suitability for long term care insurance and may not be used for any other purpose or disseminated outside of the Company or agency.

Authorization to Process Application

My agent has explained to me that my personal financial circumstances are an important consideration in determining whether or not long term care insurance is an appropriate purchase for me.

My agent has also given me a copy of "*Things You Should Know Before You Buy Long Term Care Insurance*" and has explained the importance of completing the Long Term Care Insurance Personal Worksheet.

I hereby confirm that I have chosen not to complete the Long Term Care Insurance Personal Worksheet. Nevertheless, I request that you continue to process my application for long term care insurance.

Signed: _____ _____

(Applicant) (Date)

_____ _____

(Joint Applicant) (Date)

Berkshire Life Insurance Company of America
Home Office: Pittsfield, Massachusetts
Long Term Care Administrative Office
Post Office Box 4243
Woodland Hills, CA 91365-4243
888-505-8743

Things You Should Know Before You Buy Long-Term Care Insurance

Long-Term Care Insurance

- A long-term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.
- You should **not** buy this insurance policy unless you can afford to pay the premiums every year. Remember that the company can increase premiums in the future.
- The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.

Medicare

- Medicare does **not** pay for most long-term care.

Medicaid

- Medicaid will generally pay for long-term care if you have very little income and few assets. You probably should **not** buy this policy if you are now eligible for Medicaid.
- Many people become eligible for Medicaid after they have used up their own financial resources by paying for long-term care services.
- When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.
- Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.

Shopper's Guide

- Make sure the insurance company or agent gives you a copy of a book called the National Association of Insurance Commissioners' "Shopper's Guide to Long-Term Care Insurance." Read it carefully. If you have decided to apply for long-term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.

Counseling

- Free counseling and additional information about long-term care insurance are available through your state's insurance counseling program. Contact your state insurance department or department on aging for more information about the senior health insurance counseling program in your state.

Facilities

- Some long-term care insurance contracts provide for benefit payments in certain facilities only if they are licensed or certified, such as in assisted living centers. However, not all states regulate these facilities in the same way. Also, many people move to a different state from where they purchased their long-term care insurance policy. Read the policy carefully to determine what types of facilities qualify for benefit payments, and to determine that payment for a covered service will be made if you move to a state that has a different licensing scheme for facilities than the one in which you purchased the policy.

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LONG TERM CARE INSURANCE
POTENTIAL RATE INCREASE DISCLOSURE FORM

1. **Premium Rate:** The premium rate that is applicable to you and the coverage you have applied for is shown on the application.
2. **The premium for the policy and any riders that are issued to you will be shown on the Policy Schedule of your policy. This rate will be in effect unless and until the Company requests a premium rate increase and it is approved by the state in which your policy was issued.**
3. **Rate Schedule Adjustments:**

   Premium rate or rate schedule adjustments will be effective on the next anniversary date following the date the state approves a rate increase.
4. **Potential Rate Revisions:**

   This policy is Guaranteed Renewable. This means that the rates for this product may be increased in the future. Your rates can NOT be increased due to your increasing age or declining health, but your rates may go up based on the experience of all policyholders with a policy similar to yours.

   If you receive a premium rate or premium rate schedule increase in the future, you will be notified of the new premium amount and you will be able to exercise at least one of the following options:

   - Pay the increased premium and continue your policy in force as is.
   - Reduce your policy benefits to a level such that your premiums will not increase. (Subject to state law minimum standards.)
   - Exercise your nonforfeiture option if purchased. (This option is available for purchase for an additional premium.)
   - Exercise your contingent nonforfeiture option.* (This option may be available to you if you do not purchase a separate nonforfeiture option.)

***Contingent Nonforfeiture**

If the premium rate for your policy goes up in the future and you didn't buy a nonforfeiture option you may be eligible for contingent nonforfeiture. Here's how to tell if you are eligible:

You will keep some long term care coverage, if:

- Your premium after the increase exceeds your original premium by the percentage shown (or more) in the following table; and
- You lapse (not pay more premiums) within 120 days of the increase.

The amount of coverage (i.e., new lifetime maximum benefit amount) you will keep will equal the total amount of premiums you've paid since your policy was first issued. If you have already received benefits under the policy, so that the remaining maximum benefit amount is less than the total amount of premiums you've paid, the amount of coverage will be that remaining amount.

Except for this reduced lifetime maximum benefit amount, all other policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter.

Should you choose this Contingent Nonforfeiture option, your policy, with this reduced maximum benefit amount will be considered "paid-up" with no further premiums due.

Example:

- You bought the policy at age 65 and paid the $1,000 annual premium for 10 years, so you have paid a total of $10,000 in premium.
- In the eleventh year, you receive a rate increase of 50%, or $500 for a new annual premium of $1,500, and you decide to lapse the policy (not pay any more premiums).
- Your "paid-up" policy benefits are $10,000 (provided you have at least $10,000 of benefits remaining under your policy.)

Contingent Nonforfeiture **Cumulative Premium Increase Over Initial Premium That Qualifies for Contingent Nonforfeiture** (Percentage Increase is cumulative from the date of original issue. It does NOT represent a one-time increase)	
Issue Age	**Percent Increase Over Initial Premium**
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%

In addition to the contingent nonforfeiture benefits described above, the following reduced "paid-up" contingent nonforfeiture benefit is an option in all policies that have a fixed or limited premium payment period, even if you selected a nonforfeiture benefit when you bought your policy. If both the reduced "paid up" benefit AND the contingent benefit described above are triggered by the same rate increase, you can choose either of the two benefits.

You are eligible for the reduced "paid up" contingent nonforfeiture benefit when all three conditions shown below are met:

1. The premium you are required to pay after the increase exceeds your original premium by the same percentage or more shown in the chart below;

Triggers for a Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium
Under 65	50%
65-80	30%
Over 80	10%

2. You stop paying your premiums within 120 days of when the premium increase took effect; AND
3. The ratio of the number of months you already paid premiums is 40% or more than the number of months you originally agreed to pay.

If you exercise this option your coverage will be converted to reduced "paid-up" status. That means there will be no additional premiums required. Your benefits will change in the following ways:

a. The total lifetime amount of benefits your reduced paid up policy will provide can be determined by multiplying 90% of the lifetime benefit amount at the time the policy becomes paid up by the ratio of the number of months you already paid premiums to the number of months you agreed to pay them.

b. The daily benefit amounts you purchased will also be adjusted by the same ratio.

If you purchased lifetime benefits, only the daily benefit amounts you purchased will be adjusted by the applicable ratio.

Example:

- You bought the policy at age 65 with an annual premium payable for 10 years.
- In the sixth year, you receive a rate increase of 35% and you decide to stop paying premiums.
- Because you have already paid 50% of your total premium payments and that is more than the 40% ratio, your "paid-up" policy benefits are .45 (.90 times .50) times the total benefit amount that was in effect when you stopped paying your premiums. If you purchased inflation protection, it will not continue to apply to the benefits in the reduced "paid-up" policy.

Berkshire Life Insurance Company of America
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Long Term Care Administrative Office
Post Office Box 4243
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888-505-8743

LOWERING PREMIUMS BY REDUCING BENEFITS ENDORSEMENT

This endorsement is attached to and made part of the Policy as of the Effective Date.

Lowering Premiums by Reducing Benefits

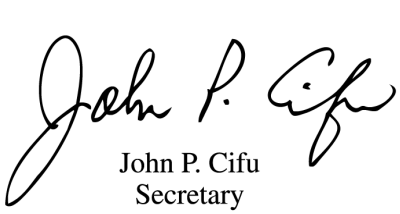
You have the option to reduce your premiums under your current coverage, subject to benefit availability, by selecting one of the following options:

- reducing the Benefit Amount shown on the Benefit Schedule; or
- reducing the Daily Benefit shown on the Benefit Schedule.

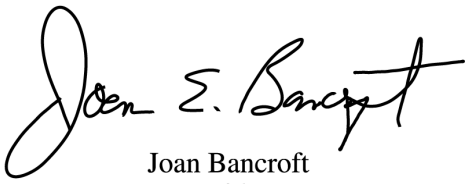
The premium rate for your reduced coverage will be based upon your age on the date your Policy was originally issued and the premium rate in effect on the date the Benefit Amount or Daily Benefit is reduced.

In the event your Policy is about to lapse due to nonpayment of premium, we will notify you of the options described above, which will become available to you in order to reduce your coverage. This notice will be sent to you at least 30 days before your Policy is cancelled for nonpayment of premium.

Executed for the Company at its Home Office in Pittsfield, Massachusetts.



John P. Cifu
Secretary



Joan Bancroft
President

SAMPLE LONG TERM CARE INSURANCE SUITABILITY LETTER

Dear [Applicant]:

Your recent application for long term care insurance included a "Personal Worksheet", which asked questions about your finances and your reasons for buying long term care insurance. For your protection, state law requires us to consider this information when we review your application. This prevents issuing a policy to those who may not need coverage.

Your answers on the worksheet indicate that long term care insurance may not meet your financial needs. We suggest that you review the information provided along with your application, including the booklet "Shopper's Guide to Long Term Care Insurance" and the page titled "Things You Should Know Before Buying Long Term Care Insurance". Your State Insurance Department also has information about long term care insurance and may be able to refer you to a counselor free of charge who can help you decide whether to buy this policy. Your state requires that we confirm your request to proceed before we can continue to underwrite your application. We need to hear from you within the next 60 days to complete the underwriting of your application.

If we do not hear from you within the next 60 days, we cannot issue you a policy and your file will be closed. You should understand that you will not have any coverage until you respond to this letter, we approve your application and issue you a policy.

Please check one box and return in the enclosed envelope.

❍ Yes, I wish to purchase this coverage. Please continue the review of my application.

❍ No. I have decided not to purchase long term care coverage at this time.

APPLICANT'S SIGNATURE _____ DATE _____

Please return to Berkshire Life Insurance Company of America at

P.O. Box 4243, Woodland Hills, CA 91365-4243 by [Date].

APPENDIX C
ISSUER CERTIFICATION FORM
(relating to Qualified State Long-Term Care Insurance Partnership)

In order to provide the Insurance Commissioner with information necessary to provide a certification for policies, this Issuer Certification Form requires information and a certification from issuers of long-term care insurance policies with respect to policy forms that may be covered under the Qualified Partnership of the State.

An insurance company may request certification of policies from time to time and, accordingly, may supplement this issuer certification form, *e.g.*, as it introduces new long-term care insurance policy forms for issuance.

I. GENERAL INFORMATION

A. Name, address and telephone number of issuer:

Berkshire Life Insurance Company of America
P.O. Box 4243, Woodland Hills, CA 91365-4243
888-505-8952

B. Name, address, telephone number, and email address (if available) of an employee of issuer who will be the contact person for information relating to this form:

Amy Ota
P.O. Box 4243, Woodland Hills, CA 91365-4243
(800) 366-5463 Extension 2324, amy.ota@lifecareassurance.com

C. Policy form number(s) (or other identifying information, such as certificate series) for policies covered by this Issuer Certification Form (expand the space below as required):

BG01P(01/09)-AR et al

Specimen copies of each of the above policy forms, including any riders and endorsements, shall be provided upon request.

II. CERTIFICATIONS

A. I hereby certify that the policy forms listed above are in compliance with Rule 13 and Rule 94 and all other Arkansas statutes and rules regarding long-term care insurance.

B. I hereby certify to the best of my knowledge and belief that all producers who sell, solicit or negotiate long-term care insurance products on {insert issuer name's} behalf have received the training required for Partnership policies and that they demonstrate an understanding of the policies and their relationship to public and private long-term care coverage.

C. I hereby certify that the answers, accompanying documents, and other information set forth herein are, to the best of my knowledge and belief, true, correct, and complete.

November 6, 2008
Date

Laura H. Rotenberg, Second Vice President and Counsel
Name and title of officer of the Issuer

Laura H. Rotenberg
Signature of officer of the Issuer

SERFF Tracking Number:	*LFCR-125795796*	*State:*	*Arkansas*
Filing Company:	*Berkshire Life Insurance Company of America*	*State Tracking Number:*	*40106*
Company Tracking Number:	*BG01 2008 ENHANCEMENTS AR*		
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*Care ProVider*		
Project Name/Number:	*/*		

Superseded Attachments

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Original Date:	Schedule	Document Name	Replaced Date	Attach Document
No original date	Form	Partnership Program Notice	08/28/2008	BG01N-PRT(01-09)-AR.pdf
No original date	Form	First Day HCCS Benefit Rider	08/28/2008	BG01R-FDC(01-09).pdf

Berkshire Life Insurance Company of America
Home Office: Pittsfield, Massachusetts
Long Term Care Administrative Office
Post Office Box 4243
Woodland Hills, CA 91365-4243
888-505-8743

Important Consumer Information Regarding the Arkansas Long-Term Care Insurance Partnership Program

Some long-term care insurance policies sold in Arkansas may qualify for the Arkansas Long-Term Care Insurance Partnership Program (the Partnership Program). The Partnership Program is a partnership between state government and private insurance companies to assist individuals in planning their long-term care needs. Insurance companies voluntarily agree to participate in the Partnership Program by offering long-term care insurance coverage that meets certain State and Federal requirements. Long-term care insurance policies that qualify as Partnership Policies may protect the policyholder's assets through a feature known as "Asset Disregard" under Arkansas Medicaid program.

Asset Disregard means that an amount of the policyholder's assets equal to the amount of long-term care insurance benefits received under a qualified Partnership Policy will be disregarded for the purpose of determining the insured's eligibility for Medicaid. This generally allows a person to keep assets equal to the insurance benefits received under a qualified Partnership Policy without affecting the person's eligibility for Medicaid. All other Medicaid eligibility criteria will apply. Asset Disregard is not available under a long-term care insurance policy that is not a Partnership Policy. Therefore, you should consider whether Asset Disregard is important to you, and whether a Partnership Policy meets your needs. ***The purchase of a Partnership Policy does not automatically qualify you for Medicaid.***

What are the Requirements for a Partnership Policy. In order for a policy to qualify as a Partnership Policy, it must, among other requirements:

- be issued to an individual after January 1, 2008;
- cover an individual who was an Arkansas resident when coverage first becomes effective under the policy;
- be a tax-qualified policy under Section 7702(B)(b) of the Internal Revenue Code of 1986;
- meet stringent consumer protection standards; and,
- must provide annual inflation protection for ages 75 and younger.

If you apply and are approved for long-term care insurance coverage, Minnesota Life Insurance Company will provide you with written documentation as to whether your policy qualifies as a Partnership Policy.

What Could Disqualify a Policy as a Partnership Policy? Certain types of changes to a Partnership Policy could affect whether such policy continues to be a Partnership Policy. If you purchase a Partnership Policy and later decide to make *any* changes, you should first consult with Minnesota Life Insurance Company to determine the effect of a proposed change. In addition, if you move to a state that does not maintain a Partnership Program or does not recognize your policy as a Partnership Policy, you would not receive beneficial treatment of your policy under the Medicaid program of that state. The information contained in this disclosure is based on current Arkansas and Federal laws. These laws may be subject to change. Any change in law could reduce or eliminate the beneficial treatment of your policy under Arkansas's Medicaid program.

Additional Information. If you have questions regarding long-term care insurance policies please contact Minnesota Life Insurance Company. If you have questions regarding current laws governing Medicaid eligibility, you should contact the Arkansas Department of Human Services.

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FIRST DAY HOME AND COMMUNITY CARE SERVICES BENEFIT RIDER

READ THIS RIDER CAREFULLY. It is a part of a legal contract between you and us.

This rider is part of the Policy. The Effective Date for this rider is shown on the Policy Schedule of the attached Policy. It is issued in consideration of your application and premium paid by you for this rider. All definitions, provisions, Limitations and Exclusions of the Policy apply to this rider unless changed by this rider.

First Day Home and Community Care Services Benefit

We will waive any Elimination Period required for Home and Community Care Services benefits. If you otherwise satisfy the Payment of Benefits provision under the Policy for Home and Community Care Services, no Elimination Period will be required and benefits will be payable on the first day you are qualified to receive benefits.

Home and Community Care Services benefits payable as a result of this rider's waiver of the Elimination Period will not count towards the satisfaction of the required Elimination Period for Facility Care Services or any other benefits under the Policy or attached riders.

Free Look Period For 30 Days

If you are not satisfied with this rider, you may return it to us or any authorized agent or agency within 30 days from the date you receive it. We will then refund any premium you have paid for this rider and this rider will be considered never to have been in effect.

Executed for the Company at its Home Office in Pittsfield, Massachusetts.

John P. Cifu
Secretary

Joan Bancroft
President